# THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

JULY, 1951

# NEW "AMERICAN" LAUNDRY... SAVES $10,000 First 7 Months

**. . . at Good Samaritan Hospital, W. Palm Beach, Fla.**

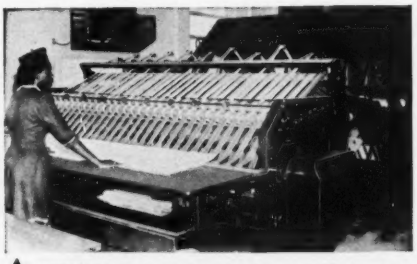
To assure a plentiful supply of clean linens for every department at lowest possible cost, 125-bed, privately owned, Good Samaritan Hospital installed an "AMERICAN" planned laundry, equipped with the latest high-production, labor-saving machines. Working closely with the architect who designed a new building for the laundry, our Survey Engineering Dept. prepared a floor plan of the equipment arrangement to insure maximum operating efficiency.

*The first 7 months* the laundry was in operation, management of the hospital reported a *saving of $10,000.* Complete control of linens . . . faster return of linens to service . . . better quality work . . . were additional benefits reported.

The free services of our Laundry Advisor are offered to all hospitals, large or small, *without any obligation whatever.* He will make a thorough study to determine if you are handling your soiled linen problem most efficiently and economically. If justified, he will recommend proper laundry equipment to meet your hospital's particular needs. WRITE TODAY. Our Laundry Advisor will call at your convenience.

**Remember . . .** *Every Department of Your Hospital Depends on the Laundry.*

▲ **Automatic, labor-saving equipment in Good Samaritan Hospital's new laundry includes CASCADE Automatic Unloading Washer (at right, above) with Full-Automatic Washing Control (center), and mechanically loaded and unloaded NOTRUX Extractor (left). Control takes washer through entire washing cycle *without operator attention.* Merely pushing buttons automatically empties entire washer load into Containers of NOTRUX Extractor *in less than a minute.* Loaded Containers are lifted into and out of NOTRUX Extractor by push-button operated electric hoist.**



▲ **TRUMATIC Folder automatically quarter-folds large linens from 6-Roll STREAMLINE Ironer, with only one receiving operator required to crossfold and stack work.**

▲ **Nurses' Uniform Press Unit enables one operator to machine-iron garments in a simple, speedy sequence which reduces ironing costs by saving time and motions.**

**The**

## CANADIAN

**LAUNDRY MACHINERY CO., LIMITED**

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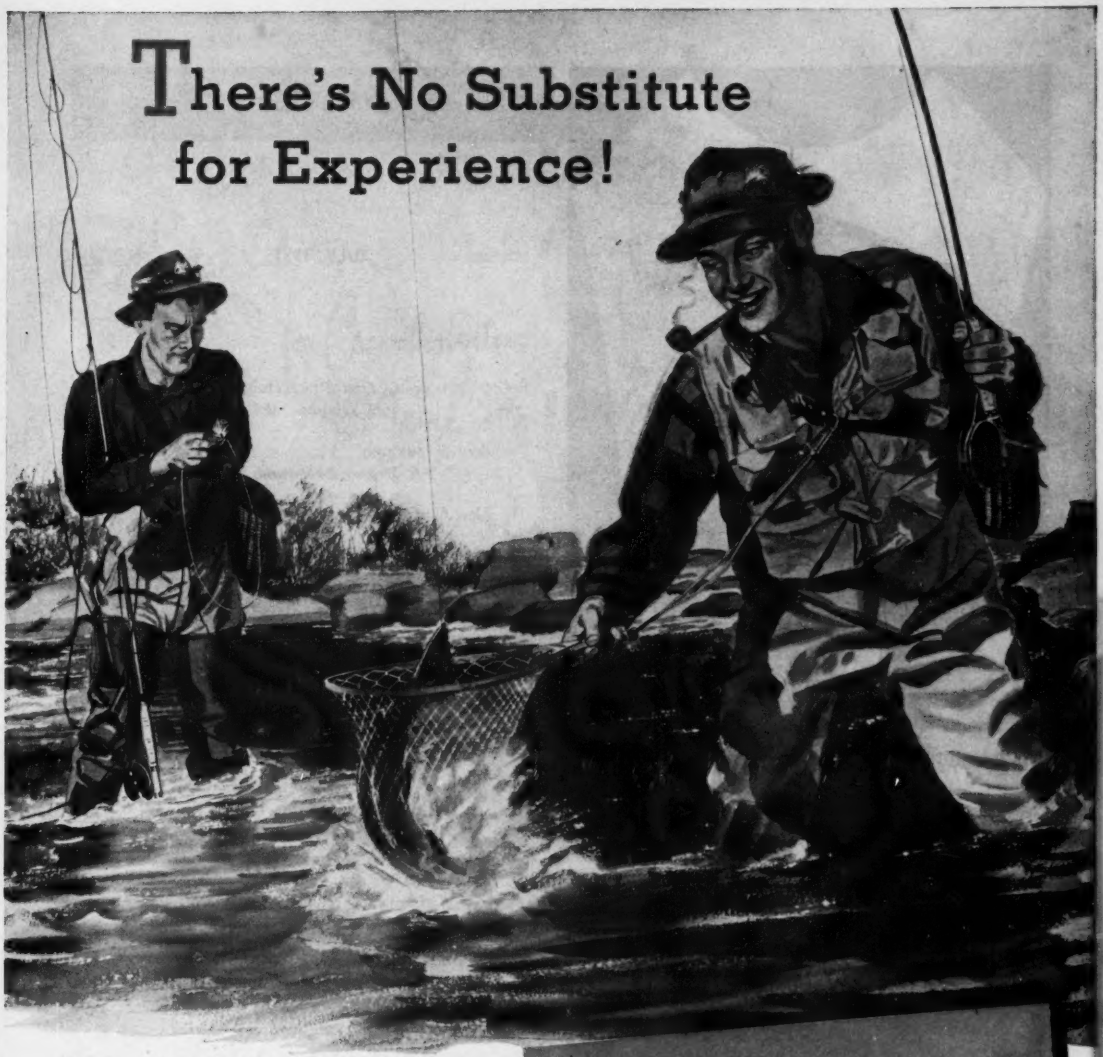
# There's No Substitute for Experience!



## ...that's why Gumpert gives you true economy in food specialties

Nothing can take the place of knowledge and skill gained through years of specialization. It's this "know-how" that enables Gumpert to combine in its products for hospitals both quality and real economy.

It's the *food cost per portion* — not the figures on the invoice — that means true economy. And Gumpert's 59 years of leadership and experience guarantee *better finished products and more of them for every dollar you invest.*

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**GUMPERT**

***Tops in Taste!* GUMPERT'S New Line of Flavor-Improved Puddings**

These puddings are truly taste delights, with their richer, more satisfying flavor, satin-smooth texture and melt-in-the-mouth tenderness. They're so quick and easy to prepare. Just add milk — boil, cool, and they are ready to serve.

CHOCOLATE BUTTERSCOTCH VANILLA FRENCH TAPIOCA

300 QUALITY FOOD SPECIALTIES FOR RESTAURANTS BACKED BY 59 YEARS OF EXPERIENCE!

# Contents

Vol. 28 **JULY, 1951** No. 7



*(For Subscription Rates see page 102)*


*for Carbohydrates...*

## *the Trend is to* 10% *Travert*®

**Twice as many calories as 5% Dextrose**
**No increase in infusion time, fluid volume or vein damage**
**Practically 100% utilization**
**Less spillage in urine**

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- To replenish glycogen stores
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***Travert*** *makes possible the administration of high caloric infusions, with minimal discomfort and inconvenience to the patient*

**10% *Travert*** solutions are available in water or in saline
They are sterile, crystal clear, nonpyrogenic
150 cc., 500 cc., 1000 cc. sizes

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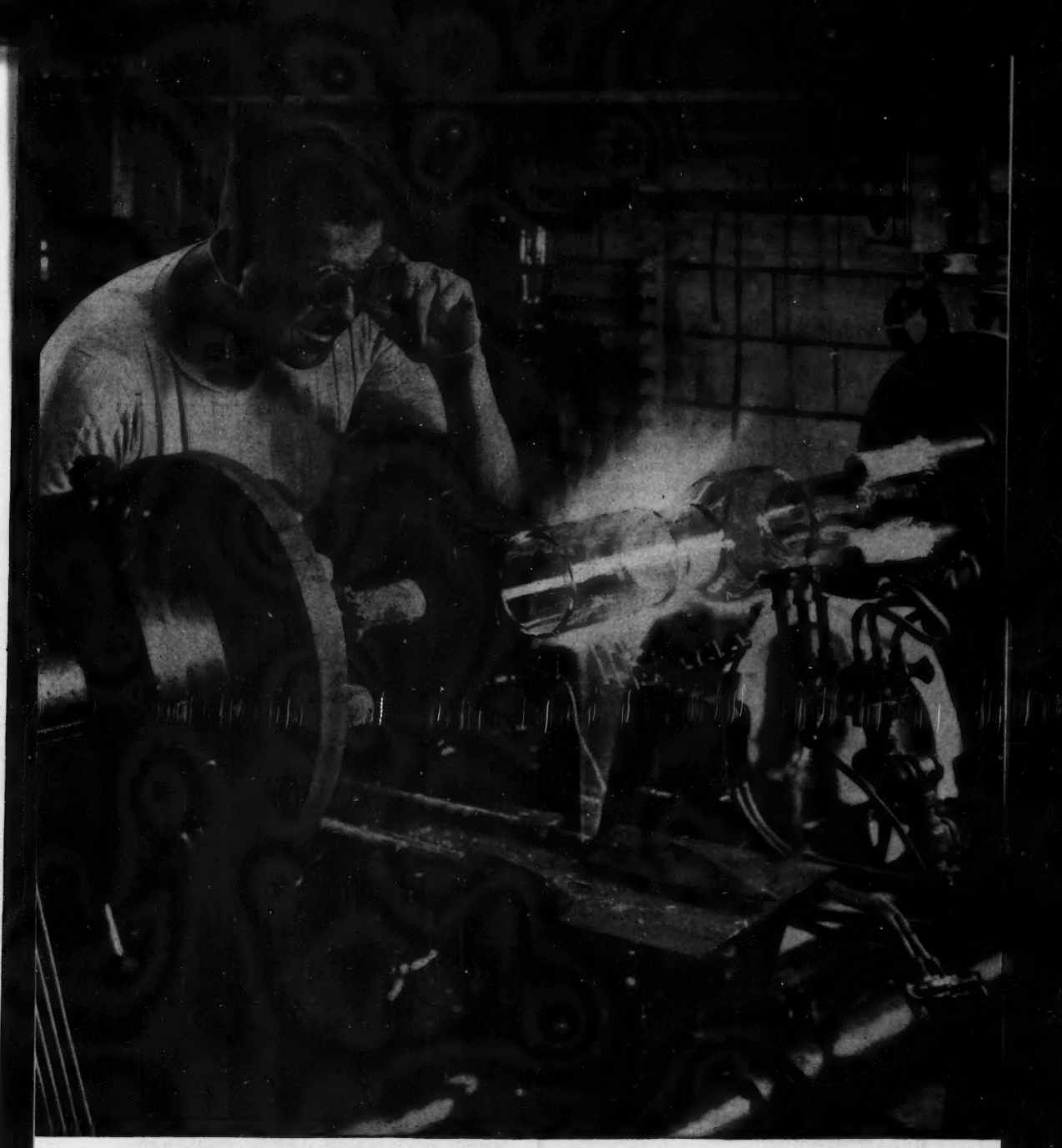

# *WANT HIGHEST QUALITY X-RAY TUBES?*

*you can put your confidence in*

GENERAL ELECTRIC
X-RAY CORPORATION
LIMITED

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141 EAST 25TH STREET,
NEW YORK 10, N. Y.
Showrooms also at 308 W. Washington St., Chicago 6, Ill.

# Clay-Adams

## Cantor Tube Gives More Positive Intestinal Intubation

**DIFFICULT CASES SUCCESSFULLY INTUBATED**

Many of the usual difficulties encountered in intestinal intubation are readily overcome by using the Cantor Tube. Nurses and doctors who follow the carefully detailed instructions report successful intubations in difficult as well as routine cases.

A combination neoprene and natural rubber bag is attached to the Cantor Tube at its distal end. When the bag is filled with a few ounces of mercury, the free-flowing properties of the mercury and the bolus-like nature of the bag and mercury aid passage of the tube through the stomach and pylorus.

Tests prove that neoprene is far less permeable to the intestinal gases than commonly-used latex bags, as it avoids earlier hazards of a high concentration of gas in the bag due to intra-intestinal pressure when the tube is in position.

Among other features of the tube are a larger luminal diameter, allowing more efficient decompression and less possibility of plugging. There are no metal parts anywhere on the tube which might injure the mucosa. Bag and tube

are so assembled and filled that air cannot enter the bag, nor can mercury escape into the tube.

Detailed instructions, in English or Spanish, on use of the Cantor Tube are available for distribution to hospital personnel in any quantity from Clay-Adams.

### *You may be interested...*

- For prolonged gastro-intestinal intubation, without irritation or tissue reaction, Levin-type tubes can be made readily from lengths of polyethylene tubing. It has been found particularly useful in the treatment of adults and premature and other infants, where feeding is a problem.
- Levy-Hausser Counting Chambers are recommended for determining eosinophil counts during ACTH treatments. These counts are a guide to blood level of ACTH.

## C.R.I.* Germicide for Heat-Labile Materials

Disinfection of heat-labile materials and appliances, such as plastics, catheters, and polyethylene plate and tubing, can be carried out safely in C.R.I. Germicide. This new non-toxic, non-irritating cold germicide has a double advantage: it is effective against all common pathogens, and it is rust-inhibiting. Costly instruments, like cystoscopes, and appliances may be left in C.R.I. Germicide with no fear of pitting or loss of cutting edge.

Descriptive literature in English and Spanish is available from Clay-Adams.

**Trade Mark*

# Newsletter

FOR THE MEDICAL AND BIOLOGICAL SCIENCES
Number 4 of a Series

**FROM CURRENT LITERATURE**

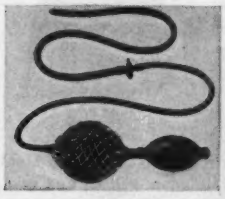
Pure polyethylene plate is finding increased use in cranioplasty. Indications are that it will eventually replace other materials, metal, plastics, and bone now in use, report Drs. Eben Alexander and Peter H. Dillard in *Journal of Neurosurgery, VII,* 6, pp. 492-498, 1950.

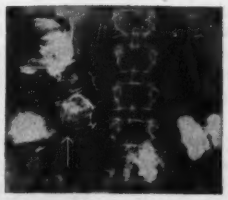
Polyethylene is readily molded by immersing in boiling water for a few seconds and then fashioning to fit the skull defect. On cooling, polyethylene retains its shape. Pure polyethylene (*i.e.*, Clay-Adams "animal-tested") causes no tissue reaction or ensuing abnormalities.

## Buckstein Air Insufflator for Colonic Aerograms

In many cases small polyps and malignant tumors escape detection by means of the conventional barium enema. An aerogram, however, immediately after evacuation of the barium by the patient, will frequently disclose such pathology, as shown in the figure below.

The Buckstein Air Insufflator permits gradual entrance of air into the colon. Air is pumped from one bulb into a second bulb, and its flow into the colon controlled by a petcock. Patient distress is minimized since an even, gradual flow is more readily tolerated.





*Left: Buckstein Insufflator*
*Right: Aerogram—papilloma visualized*

## *Skeletons and Anatomical Models Help Doctor-Patient Relations*

Better patient relations with the doctor often depend on the patient's understanding of his ailment and the prescribed treatment. This requires education of the patient—most effectively accomplished by visual aids. For this purpose, Clay-Adams offers, for the first time in many years, prompt delivery on a complete line of skeletons, the well-known DURABLE pressed paper anatomical models, and charts.

**Ten Thousand MEDICHROME Subjects** have found their place in post-war teaching programs of many so-called "backward countries." With only inexpensive projection equipment and slides, effective teaching programs have been instituted without delay. MEDICHROMES (2 x 2" Kodachrome slides) cover practically all phases of the medical, nursing and biological sciences. Write today asking for complete listings in *your* specialty.

**SPECIAL LITERATURE AVAILABLE**

Detailed descriptions on the following may be obtained from Clay-Adams on request by number:

| | |
|---|---|
| Polyethylene Tubing and Accessories | Form 447B |
| Skeletons | Form 493 |
| DURABLE Anatomical Models | Form 494 |
| Buckstein Insufflator | Form 348B |
| Cantor Tube | Form 406D6 |

*Clay-Adams Company, Inc.* 141 EAST 25TH STREET, NEW YORK 10, N. Y.

CLAY-ADAMS PRODUCTS DESCRIBED ON THESE PAGES ARE AVAILABLE FROM LOCAL SURGICAL SUPPLY DEALERS

# Across the Desk

By C.A.E.

**Rays of Radioactive Cobalt To Be Studied**

Powerful "supervoltage" rays of radioactive cobalt will soon be studied as a possible new aid to cancer sufferers.

A special apparatus for administering the rare isotope —possibly the first unit of its kind—will be delivered to the Oak Ridge Institute of Nuclear Studies and M. D. Anderson Hospital by General Electric X-Ray Corporation of Milwaukee within the next several months, officials of both groups revealed recently.

Located in Oak Ridge, Tenn., adjacent to the Atomic Energy Commission plant, the institute will co-operate with the M. D. Anderson Hospital of Houston, Tex., affiliated with the University of Texas, in extensive tests on radioactive cobalt and its effects on cancers.

The radiation emitted by cobalt 60, as it is known, is equivalent to the X-rays produced by high-voltage tubes operating at about 1,200,000 electron volts. Four cobalt wafers, each less than one inch square and less than an eighth of an inch thick, are being irradiated in the Chalk River, Canada, atomic energy reactor, for use in the new unit. The cost of an equivalent amount of radium ($26,000,000) would be several thousand times greater.

* * * *

**Simplified Uniform Purchasing**

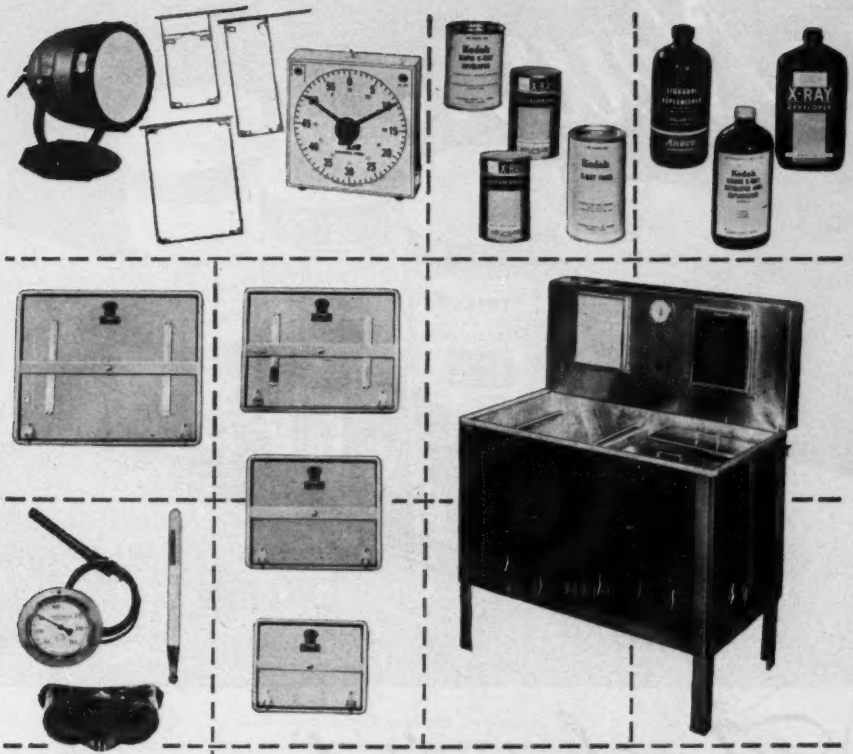
Angelica Uniform Company have introduced an idea which they state simplifies uniform purchasing with "multi-purpose" garments and permits the hospital buyer to purchase in larger quantities at lower prices.

All this is made possible by using one style of garment in such departments as housekeeping, dietary, nurses' aid, and maintenance. Only the colour would change by department. Thus one source of supply can make the problems of uniform buying simpler and larger quantities, meaning lower prices, may be bought because buyers for different departments may combine their orders.

One of the multi-purpose garments offered by Angelica is illustrated. It has a white Broadcloth blouse and Monte cloth pinafore in choice of grey, aqua, yellow, and rose.

Colour illustrations of this and other Angelica styles for all hospital departments are shown in the Angelica Hospital Apparel Catalog which may be had by writing to Angelica Uniform Company of Canada, Limited, 427 St. Francois Xavier St., Montreal, Quebec.

*(Continued on page 16)*




## X-Ray Supplies of Proven Merit

**High quality materials are extremely important to good diagnosis. We are distributors of the country's foremost x-ray supplies and accessories.**

**Only a few of the many products available for prompt, efficient delivery, are illustrated.**

### The New Keleket Cassette

**Tubular Monel Metal frame—extremely light and tough.**
**Reinforced corners—maximum strength to resist damage.**
**Special cassettes: (1) for new air-bag backed screen.**
**(2) with built in Lysholm-Schonander grid.**
**(3) new design for special film identification.**


### The X-Ray Darkroom

**Developing tanks to meet all requirements.**
**Stainless steel construction.**
**Stainless steel developing insert tanks.**
**Stainless steel darkroom accessories.**

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# The Surgiset*

SKIN CLOSURE SUTURES

## FILLS A REAL NEED IN EMERGENCIES

## Complete Emergency Suture Assortment IN STERILE PACK JARS, READY TO USE

**NEW** . . . A handy way of having your sutures always readily available.

**NEW** . . . Stronger needles: Fine sizes for facial wounds; heavy sizes for toughest skin.

You don't waste time boiling tubes when you have the Surgiset. The germicide in every jar keeps tubes sterile.

Surgiset contains 3 dozen Atraloc eyeless needle sutures: 5-0 monofilament nylon on small cutting needle for facial repair; 3-0 dermal on medium cutting needle for normal skin repair; 2-0 dermal on heavy cutting needle for heavy skin.

Surgiset contains an extra jar for storing your other sutures.

Supplied complete with chrome-plated rack for the regular price of 3 dozen emergency sutures. (Jars and rack given without charge.) Refills are available, ready for use in sterile packed jars, at no extra cost.

***Order From Your Surgical Dealer***

**ETHICON SUTURE DIVISION**

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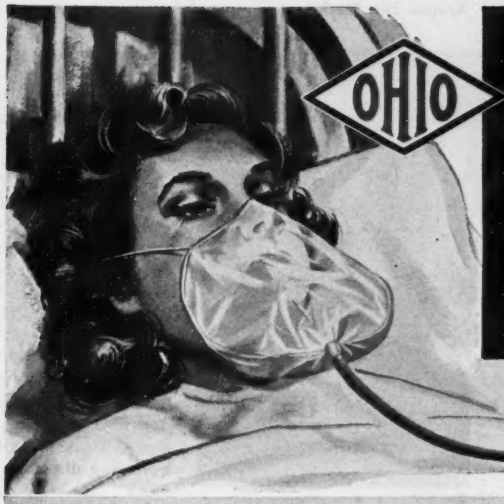

# INTRODUCES THE K-S *disposable** OXYGEN MASK

Once again OHIO makes a valuable contribution to added efficiency, comfort and convenience in oxygen therapy with this new, inexpensive K-S Disposable Oronasal Oxygen Mask.

**LIGHTWEIGHT** . . . This clear, transparent plastic mask is light as a fine handkerchief. Its pleasing appearance and soft texture make the patient fully receptive to its use.

**SANITARY** . . . It is worn by one patient, then discarded. Dangers of contagion or cross infection are avoided and costly time-consuming sterilization processes are eliminated.

**COMFORTABLE** . . . Spacious rebreathing bag allows deep respiration in complete comfort. And pliability avoids anxiety caused by heavier, more rigid permanent type masks.

**EFFICIENT** . . . The K-S Disposable Mask is usable with any oxygen therapy system. The snug, pressure-free fit and leakproof seams assure complete dependability. And K-S Masks can be stored for long periods before use without danger of deterioration . . . Saves storage space too . . . 100 K-S Masks occupy the space of ONE permanent type mask.

**FOR EFFICIENCY, COMFORT AND ECONOMY USE OHIO'S NEW K-S DISPOSABLE OXYGEN MASK**

***Write TODAY for prices in quantity lots and descriptive literature.***

* Use it . . . Discard it! Packed for economy in boxes of 50.

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OHIO HOSPITAL EQUIPMENT — Heidbrink Anesthesia Apparatus • Ohio Oxygen Therapy Apparatus • Kreiselman Resuscitators • Scanlan-Morris Sterilizers • Ohio Scanlan Surgical Tables • Operay Surgical Lights • Scanlan Surgical Sutures • SterilBrite Furniture • Recessed Cabinets.

OHIO MEDICAL CASES — Oxygen • Nitrous Oxide • Cyclopropane • Carbon Dioxide • Ethylene • Helium and Mixtures • Also Laboratory Gases and Ethyl Chloride.

## Across the Desk

*(Continued from page 12)*

### Mathews Conveyer Company Executive

Leonard T. Sylvester, president and general manager of Mathews Conveyer Company, Limited, Port Hope, Ontario, was recently elected senior vice-president of the parent company, Mathews Conveyer Company, Ellwood City, Pennsylvania. Mr. Sylvester joined the Mathews Canadian Organization in 1912 and was elected treasurer and managing director in 1925. He became president and managing director in 1949, the office which he holds today, in addition to his new office in the parent company.

This company manufactures the "Sub-veyor" system of food distribution used in many Canadian hospitals.

* * * *

### New Product—Tri-Pad* Disposable Underpads

Johnson & Johnson recently announced the release in Canada of this unique and exclusive disposable underpad. Shortly after the initial release unexpected raw material shortages developed, necessitating drastic curtailment of available stocks.

Hospitals throughout Canada will welcome the news that TRI-PADS are once again in free supply. TRI-PADS have already proved, both in the United States and Canada, that they offer substantial savings in the way of labour, nurse hours and linens. Some hospitals have computed these savings as high as three dollars per bed per annum.

In addition to their efficiency TRI-PADS are comfortable to the patient, being faced with soft, absorbent Masslin* non-woven fabric (more comfortable than gauze) followed by multiple layers of absorbent tissue and backed by a specially treated water-repellent paper.

Major uses are for maternity and incontinent patients, also for orthopædic patients to protect bed-linen from abrasions caused by plaster-of-Paris casts. TRI-PADS are helpful in the accident or emergency room where bleeding is profuse and on stretchers in the ambulance. Multiple other uses find TRI-PADS a welcome new aid to the hospital economy.

Samples and literature are available through your J & J hospital representative or by writing to the Hospital Division, Johnson & Johnson Limited, 2155 Pius IX Boulevard, Montreal 4.

* Trade marks.

*(Concluded on page 20)*

NEW, IMPROVED

# WEAR-EVER ALUMINUM

## REPAYS ITS COST WITH EXTRA YEARS OF SERVICE!

## Replace old, battered utensils with smooth-cooking, heavy duty WEAR-EVER!

WEAR-EVER Heavy Duty Utensils as shown in these photographs, give extra long wear. They're made of an especially hard, aluminum alloy and have double-thick edges and bottoms. At left is shown the heavy duty sauce pan with long handle and loop handle. Also made with loop handles, only. Close-fitting covers also available. Cooks evenly from bottom and sides.

## Made from Extra Thick, Extra Tough *ALUMINUM* alloy

WEAR-EVER is smooth-cooking because it spreads heat fast and evenly. This new Double Boiler is a wonderful utility utensil in *any* kitchen. Use it for cooking cereals, puddings, cream soups, sauces, newburg. With ice in the bottom . . . for butter, fruit, puddings, etc. In the bakeshop . . . for cream pie fillings, fruits, etc. Loop handles on both pans, Bakelite knob for easy handling.

H-351

*Get in touch with your Supplier, or write...*

**WEAR-EVER PROFESSIONAL CUTLERY**

As leaders in the kitchen utensil field, we now offer the finest cutlery obtainable. WEAR-EVER knives are made from high carbon chrome-venadium steel. Blades are razor-sharp, non-corrosive and set in hand-fitting, ebonwood handles.

**ALUMINUM GOODS LIMITED**

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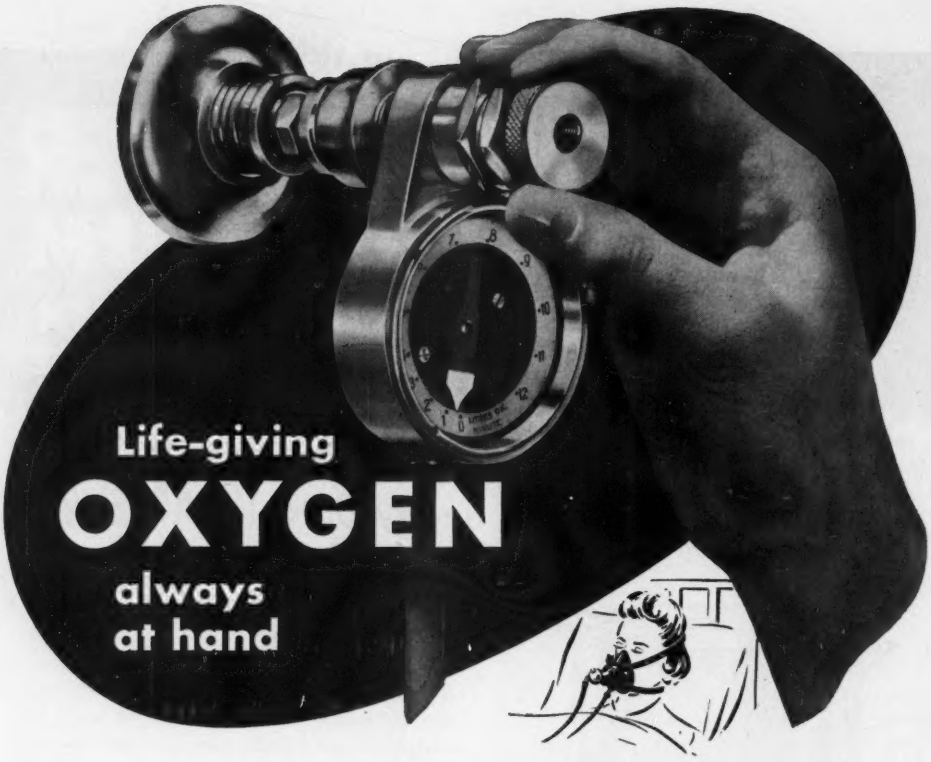


## with L.A. Hospital Pipeline Equipment

Oxygen is always immediately available when it's needed with a hospital pipeline system. L.A. station outlets provide exactly the oxygen service required in any part of the hospital.

Pipeline systems are more economical and more efficient than other distribution methods for the hospital and are less disturbing to the patient. Handling costs, as well as the loss of time and effort in moving cylinders from place to place in the hospital, are eliminated. Patients are no longer upset by the sight of oxygen cylinders when gas is supplied through a wall outlet in the same manner as water or gas in the patient's own home.

Half a lifetime devoted to the production and supplying of gases has established for Canadian Liquid Air an enviable reputation for purity of product and excellence of service.

For expert technical opinion on how a gas distribution system can benefit your hospital, contact your nearest L.A. branch office.

*Medical Gas Division*

Canadian **LIQUID AIR** Company
LIMITED

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**Medical and Anaesthetic Gases and Mixtures**
**McKesson and Foregger Equipment — Gas Distribution Systems**

## Across the Desk

*(Concluded from page 16)*

**Harry D. Cook, President of Pharmaceutical Association**

The general manager of Abbott Laboratories Ltd., Montreal, Harry D. Cook, was elected president of the Canadian Pharmaceutical Manufacturers' Association at the recent annual meeting at Ste. Adele, P.Q.

Mr. Cook had been vice-president of the Association since May, 1949, and an executive council member since 1947. He had also been chairman of the health insurance committee since 1945.

* * * *

**West's Anti-Skid Floor Treatment**

For a high gloss floor finish that provides exceptional resistance to traffic wear, West Disinfecting Company has introduced its new floor treatment, Westwax. This new treatment is a companion product to the company's well-known Kwykwax, which is recommended for use when high gloss properties must be sacrificed to anti-skid qualities. Kwykwax contains less carnauba wax than the new Westwax, but it has extremely high anti-skid properties.

A water-soluble wax which dries within 20 minutes, the new Westwax leaves a high gloss finish without buffing or polishing. It can be used for all types of floors, including varnished wood, linoleum, rubber or composition tile, and terrazzo, and produces a hard luster with good anti-slip properties.

Kwykwax is also a water-emulsion wax, intended for use on the same type of floor coverings as recommended for Westwax. Kwykwax helps bring out the original colour of floor surfaces, is durable and water-resistant. Both Kwykwax and Westwax have been listed by the Underwriters' Laboratories Inc. as anti-slip floor treatment materials and are approved by the Rubber Manufacturers' Association.

Complete details on both Westwax and Kwykwax can be obtained from West Disinfecting Company, 42-16 West Street, Long Island City 1, N.Y.

* * * *

**New Mechanical Diswashing Compound**

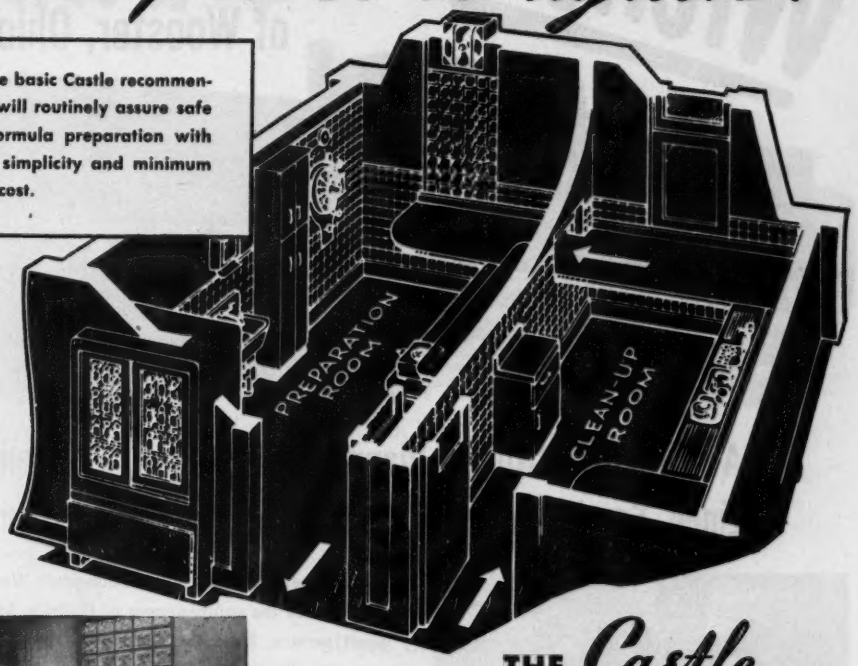
A new product, "Diversey Ampolite", is especially compounded to overcome many mechanical dish and glass washing problems. "Diversey Ampolite" has been tested and proved to give the highest efficiency in all makes of dish and glass washing machines, regardless of hardness of water. It will not attack the many metals and alloys used in the construction of newer, modern machines. The advanced water softening principles incorporated prevent scale formation, eliminating clogged wash jets and streaked dishes and glasses.

Through unique compounding and specialized chemical action this compound, it is stated, removes most stubborn contamination and suspends it from re-depositing on the dishes or glasses.

For complete particulars write to The Diversey Corporation (Canada) Limited, Lakeshore Road West, Port Credit, Ontario.

# *Castle proves it again!*

**. . . These basic Castle recommendations will routinely assure safe infant formula preparation with greatest simplicity and minimum per-unit cost.**




Where practical, as in Castle's recent Genesee Hospital installation, windowed storage refrigeration facilities afford practical supervisory advantages and visitors are happily impressed.

## THE *Castle* MILK FORMULA ROOM TECHNIC

- Provides for meticulous cleansing, rinsing and draining of bottles, nipples and accessories within the area designated as the receiving or clean-up section . . . time and cost are saved by terminal sterilization in the concluding process.

- In the preparation section of the Formula Laboratory, terminal heating of bottled and nippled formulas at 230°F. for 10 minutes is sufficient to produce formulas that are bacteriologically safe . . . terminal sterilization permits the use of single door autoclave construction which offers a triple saving in cost, installation and personnel. Its safety concentrates all steps in one simple process.

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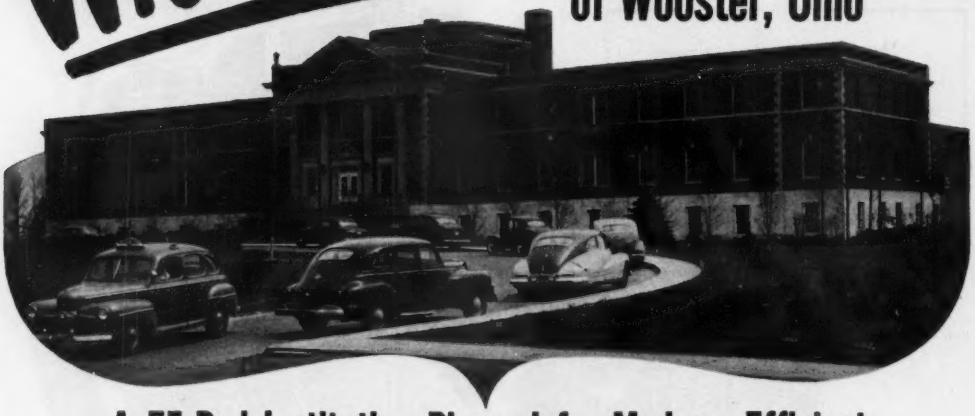
# Witness the Wooster Community Hospital of Wooster, Ohio



## A 75-Bed Institution Planned for Modern, Efficient Linen Service with HOFFMAN Laundry Equipment

Three sizes of Hoffman "Silver Crest" washers provide flexibility for any combination of soiled linens. Extractors are 40-inch "Open Top" and 17-inch "Vorsec" (not shown).

Fast, high-quality production of flatwork is accomplished on this 4-roll, 110-inch Hoffman Ironer, complete with canopy . . . faster drying with "Greyhound" tumbler (not shown).

Recent opening of this private, non-profit Wooster hospital emphasizes the *completeness* of Hoffman laundry equipment service. Even the smallest laundry is big in importance. That's why Hoffman is prepared to furnish the right size and type of machinery for laundries with smaller linen loads. And offers the same engineering survey and planning assistance provided to larger institutions. Scores of medium- and small-size hospitals have gained top linen output, lowest operating cost and maximum convenience by calling on Hoffman's specialized engineering counsel. Request it for your laundry planning.

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L. O. Bradley, M.D., Editor

THE CANADIAN HOSPITAL

Toronto, July, 1951 Vol. 28 No. 7

# Obiter Dicta

## Trans-Canada Medical Service Plan Born

THE voluntary prepaid medical care plans across Canada announced, at the Canadian Medical Association meeting in Montreal last month, the formation of a country-wide organization, to be known as Trans-Canada Medical Services, which will permit an interchange of prepaid medical care benefits among all provinces. (See page 60.) It is of equal importance that this new enterprise has the approval and blessing of the Canadian Medical Association which encouraged and directed its birth through the Committee on Economics. This extension of service follows the lead of the non-profit prepaid hospital care plans (Blue Cross) which, in 1948, inaugurated a Canadian Council of Blue Cross Plans and, in January of this year, adopted the Inter-Plan Service Benefit Bank.

The move is a good one and long overdue. On a national basis, it makes possible the provision of the "package" plan of medical and hospital care, currently so popular. The present limitations of full benefit within provincial boundaries has been a definite handicap to the individual plan and to the whole cause. With this new charter, the individual plans have gained an instrument that should allow a significant extension of service and enrolment.

It does not rest here. Both the hospital field and the medical profession must grasp this new advantage and act upon it. It is one thing to nod acceptance to an idea but quite another to launch out and actively sell it to the community. If there is not a major increase in enrolment across the country when administrative machinery has been put into shape, the individual doctor and individual hospital will have to shoulder the blame. Both groups have supported the thesis that non-profit plans can do the job better than any other agency in the community. They now have the challenge and the opportunity to prove they are right. If this challenge is not met, other agencies or methods may have to be called upon to do so.

Our best wishes to Trans-Canada Medical Services.

## Now We See It, Now We Don't

THE statement of the Minister of National Health and Welfare concerning five new changes in the hospital construction grant was a most welcome one and was received with great enthusiasm at the recent C.H.C. biennial meeting in Ottawa. This liberalizing of regulations went a fair distance towards balancing the situation of inadequate service facilities for beds in use. The provision of a per-bed grant for nurses' residences is a notable example, for here an unbalanced situation has been growing steadily.

However, the excitement and warmth created by this announcement was short-lived, and the scene quickly changed to one of gloom and despair. Before the afternoon meeting ended, the assembly was advised that building materials and supplies were in extremely short supply and that it would be difficult, if not unwise, to contemplate any further construction. It was said that, by mid-year, certain vital building materials would be practically unavailable.

It would be indeed unfortunate if the building program begun in 1945 could not be completed. Short of an actual war emergency, it would be a false and dangerous economy to allow this to happen. Due to a decade of depression and six years of war, hospital facilities had fallen far behind the needs of the country. Only now, after five busy years, are we within reasonable distance of repairing this gap.

Today, more than ever before, hospitals are vital agencies in preventing ill health and in maintaining a healthy, active populace. It is a well-known axiom that a healthy nation is a strong nation. Our leaders must keep this in mind.

Because of the hospitals, each medical man, each nurse, and every other health worker, is able to serve more patients and with greater efficiency. It is well known that we need more personnel for all departments of hospital work. Therefore it is more than ever important that Canada have adequate hospital facilities and equipment to meet the expanding range and volume of medical care. This is so in peacetime; it would be urgent in the event of war when the armed services would deplete the specialized staffs of our hospitals.

If the nation is to be brought to the state of balanced preparedness, the health facilities of its individual communities must also be kept in equilibrium. In order that hospital construction can continue, a very high priority rating should be granted and some assurance be given that supplies will be forthcoming. This principle has been recognized in the United States to the extent that additional measures to stimulate hospital construction in defence and other vital areas are under active consideration. It may not be necessary or possible here in Canada to develop new measures for encouraging and maintaining hospital building. However, at least the present program should be sustained by an adequate and steady flow of materials and supplies. If our present building program is handicapped now, it will be a serious blow to the national health program which has been developing so well during the past three years.

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# Rehabilitation in General Hospitals

**G. Gingras, M.D.,**
**Medical Director,**
**Rehabilitation Society for Cripples,**
**Montreal, P.Q.**

PROGRESS in medicine, prolonged life span, and proof that disabled persons are employable or can be rehabilitated to family or institutional life, with a minimum of help and care, has been food for thought and planning in medical and lay circles.

The concept of this "third phase of medicine" has been approached from every angle. Some associate rehabilitation with sheltered workshops, others call it social adjustment and, recently, it has been stated that there is no rehabilitation without employment. These beliefs certainly ignore the multitude of severely disabled who, in spite of all efforts, remain incapable of productive employment but who can become wholly or partially self-dependent, relieving fellow-citizens for more useful occupations and easing the country's economy.

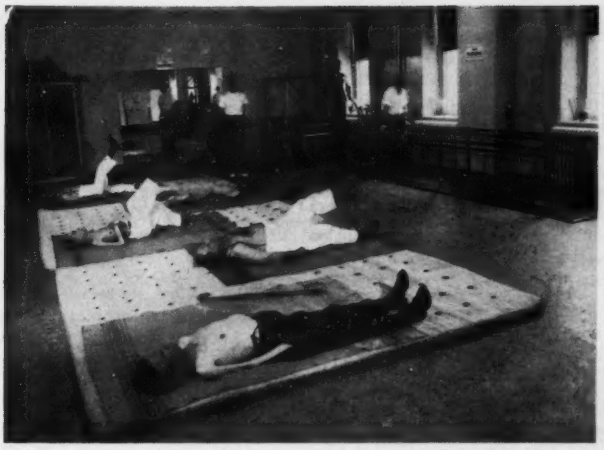
Rehabilitation starts, and should start, in hospitals, and the training of future co-ordinators of rehabilitation and their associates must begin in universities and teaching schools. Medical students are initiated to preventive medicine, medical and surgical techniques, and even taught the fundamentals of physical medicine in a few of our medical schools. Physical medicine, as known in most centres today, is a means of diagnosis and treatment, as in any other medical medium available in hospitals or in general practice. Unfortunately, few have realized that following the acute stage of illness, physical medicine is the basic instrument of rehabilitation. If physical medicine remains at its present level in Canada, young doctors contemplating this specialty as a career will continue to see no future other than dealing with diathermy and massage and, undoubtedly, it will be increasingly difficult to draw them into this field. It is well known that only a few physiatrists are accredited by the Royal College of Physicians and Surgeons of Canada.

The logical solution would be to teach rehabilitation, with physical medicine as its principal key, in place of physical medicine alone. Moreover, perhaps the specialist certification in physical medicine should be revoked and doctors be certified in physical medicine rehabilitation as in the U.S.A. A review of the examinations of the American Board of Physical Medicine Rehabilitation portrays the importance of rehabilitation alone.

The introduction of a rehabilitation program to the nursing, social service, psychology, education, physio- and occupational therapy professions is strongly indicated. Courses and training for placement and vocational officers should be created in universities and raised to a professional level. At present, there is a great waste of all these facilities due to lack of co-ordination in most institutions and organizations, with resultant costly duplication.

### Hospital Program

A rehabilitation program in any hospital where a department of physical medicine is already in operation could be instituted without much difficulty. Every patient admitted might automatically be referred to physical medicine rehabilitation and cases with minor ailments, or without rehabilitation problems could be left pending. Otherwise, where a long hospitalization is expected, or where a crippling handicap may follow, an immediate rehabilitation approach and planning, with the co-



—*Photos courtesy the Queen Mary Veterans Hospital, Montreal.*

*The gymnasium provides for physical restoration. Group or individual classes are conducted depending on extent of disability.*

operation of the treating doctor or surgeon, is necessary. In many instances, even during the acute phase of illness, plans can be formulated with the family, the former or prospective employer, if not the patient himself. This necessarily means an early and sound prognosis, home visits and interviews, and maintaining the morale of the patient and his family. As rehabilitation procedures cannot be completed in the active medical wards of general or special hospitals, a specific ward for the rehabilitation of selected patients is advisable.

The responsibility and influence of the original doctor or surgeon should prevail throughout this entire period. A doctor trained in physical medicine rehabilitation, however, is best qualified to administer and co-ordinate the rehabilitation scheme.

Apart from the usual ward or department staff, physio- and occupational therapists, medical social workers, vocational and rehabilitation officers, and remedial physical training instructors are invaluable adjuncts of this department. A permanent key staff is essential in rehabilitation work, since rotation always disturbs patients and staff relationship and inadvertently causes a break in the continuity of the scheme. Ancillary departments, i.e., psychology and speech therapy, should be available upon request.

Owing to the fact that follow-up and, at times, further surgical procedures and/or consultations, are necessary in the course of rehabilitation, it is of utmost importance that regular visits from the medical and surgical services be instituted.

There must be close proximity between the rehabilitation ward or department and physical medicine department, as well as gymnasium and hydrotherapy room, to eliminate loss of time in the management of treatments. Two wards are required in civilian general hospitals, but physical medicine rehabilitation requirements can be jointly utilized by both male and female patients, as well as by children in many instances.

The atmosphere of the rehabilitation ward must differ from the usual medical or surgical ward. It is urged that the patients be fully dressed and that the traditional "nightgown and slippers" be forgotten. This simple move is the patient's first step towards independence and normalcy.

The responsibility for organized group activity or entertainment rests with the recreational supervisor and benevolent societies. Week-end passes are to be encouraged and are to be interpreted by the patient as a recognition of his efforts and, therefore, a privilege. The staff realizes that this procedure is an excellent method of establishing a rehabilitation prognosis; and it also enables them to weigh the family's attitude toward the approaching home-coming of the trainee.

**Teamwork**

It can never be over-emphasized that rehabilitation is the result of sound teamwork. An adequate program cannot be established without comprehensive planning, and no project will bring the desired result unless all aspects are discussed at staff rehabilitation meetings. Examina-

*(Concluded on page 70)*

*Group conferences are vital in rehabilitation procedures in order to achieve a co-ordinated program.*

# Presidential Address
## to the Canadian Hospital Council

**R. Fraser Armstrong,**
**B.Sc., F.A.H.A.**
**Superintendent,**
**Kingston General Hospital,**
**Kingston, Ont.**

TWENTY years have passed since the Canadian Hospital Council was formed. During most of those years it has been my privilege to be associated with its work. This association has afforded an opportunity of knowing and appreciating the work accomplished and the personal qualities of those accepting the actual administrative responsibilities. For these reasons the office of President was assumed, two years ago, with a deep sense of pride in the organization and with a knowledge of the responsibilities involved.

### Objects

The Council, as originally envisaged, was to be a co-ordinating body for the provincial associations and conferences. It was to watch pending legislation and exert all possible influence for the benefit of the patients who enter our hospitals for care and treatment.

The first objects remain but have broadened from year to year. One thinks of negotiations with governmental agencies; of the valuable circulating and reference library; the educational aspects of Council work carried out largely through the medium of the Journal and bulletins; as well as many other advisory services.

### Liaison With Associations and Conferences

The member organizations can be served best by the Council when its officers and executive officials are familiar with the considerations facing each member organization. This knowledge can best be obtained by visiting these organizations when they are holding their annual conventions, and by a continuous interchange of correspondence.

The liaison policy undertaken during the past two years has followed the pattern of team work. The President and other honorary officers formed one liaison team and the permanent executive officials another. There has been an attempt to have a representative of each of these two teams attend each provincial association and conference meeting. Also, Council officers and executive officials have co-operated in planning and conducting the different institutes. Having acted as General Chairman of the Ontario Institute, I found this assistance most helpful. That must have been the experience of others.

It was my privilege and pleasure, as a part of the visiting team, to make one trip west and another trip east. On behalf of the Council, I attended conventions in Calgary, Vancouver, St. Andrews, and Quebec. This afforded an opportunity of reviewing problems of the member associations and this broader knowledge made it possible for the Council to render a better service.

I would like to record appreciation of the cordial reception given to me and of the opportunity to participate in the various programs. I am certain that my senior representatives, who as a part of their liaison responsibility visited other conventions, had the same beneficial and happy experience. They would want me to express thanks on their behalf for the many courtesies extended.

*Some members of the executive of the Canadian Hospital Council. Back row, left to right: Murray Ross, Dr. W. D. Piercy; Percy Ward; R. Fraser Armstrong, retiring president; Dr. A. L. C. Gilday; and Dr. L. O. Bradley.*

*Front row, left to right: Rev. Father H. L. Bertrand; Dr. O. C. Trainor, newly-elected president; and Dr. A. C. McGugan.*

### The Library

Well-qualified librarians, under the supervision of Council secretaries, have developed a hospital library which in its field is second only to

the Bacon Memorial Library in Chicago. This service is available to all hospitals.

### The Journal

*The Canadian Hospital* became the official journal of the Council in 1936 and 10 years later it became the property of the Council. Ownership brought the advantages of policy control. Under able and sound editorial supervision and execution, there was the assurance of reliable information being directed to readers. Our journal must not be controlled by outside interests for ulterior and hidden motives.

Concentration in educational publicity has advantages, providing a proper balance is maintained. A policy of concentration, at the same time protecting the general balance, has been adopted during the past year. A considerable portion of certain issues gives reasonable emphasis to specific administrative interests. The February issue concentrated upon construction and May featured the hospital pharmacy. An early number will be devoted to the dietary department and we hope later to emphasize hospital maintenance.

The journal is an asset which must be protected and the hospital field generally should rally to its support if weakening inroads ever become apparent.

### Where Does the Income Come From?

The income to finance Council undertakings comes from the voluntary assistance given by the member associations, a highly appreciated contribution from the Sun Life Assurance Company, and a very modest profit on the Journal. About one-half of this is used to meet the salaries of the permanent staff and the remainder for office rent, printing, and general expenses. All expenses are carefully scrutinzed and the books are duly audited.

When new or additional expenditures become necessary, the Council must look for additional support. Therefore, when the delegates, at the 10th biennial meeting, declared themselves in favour of the appointment of an assistant secretary, it was obvious that this declaration on their part carried with it an obligation. That obligation was to recommend further financial support from the associations and conferences which they represented.

There was an encouraging response but additional financial support is required. Your executive has been giving serious consideration to this problem. It has been proposed that a part of our public relations effort should be directed towards the large group of citizens, from one end of Canada to the other, who enter our hospitals as patients.

*(Continued on page 66)*

* * * *

## Un Résumé

Mes révérendes Soeurs, Mesdames et Messieurs. Il me fait plaisir de vous donner, en français, un résumé du magnifique exposé que vient de présenter monsieur Armstrong.

Vous savez tous et toutes, dit-il, que le Conseil des Hôpitaux du Canada existe depuis vingt ans, qu'il a accompli un travail merveilleux et que, dès son origine, son but principal fut d'être un agent de liaison entre les différentes associations et les conférences. Depuis, son champ d'action s'est largement étendu et il n'est plus un simple agent de liaison.

Vous avez à Toronto, dans les bureaux du Conseil des Hôpitaux du Canada, une manifique bibliothèque, parfaitement organisée, et dont vous pouvez vous servir à loiser.

*The Canadian Hospital Journal* est l'organisme officiel du Conseil des Hôpitaux du Canada. A ses débuts, il était la propriété de monsieur Edwards. Il y a dix ans, ce dernier a gracieusement consenti à en faire cadeau à l'Association.

Parlons maintenant d'argent, puisqu'il faut en parler. Nos revenus proviennent principalement des associations et des conférences. Il nous viennent également de la Sun Life, qui a apporté, au cours des dernières années, une contribution considérable. Il nous faudra trouver encore d'autres sources de revenus, puisque nous avons un secrétariat beaucoup plus considérable qu'autrefois.

Le docteur Agnew est personnellement disparu de la scène, puisqu'il est maintenant à son compte avec la firme Neergaard, Agnew and Craig. Pour le remplacer, nous nous sommes assurés les services du docteur Bradley, auquel nous avons adjoint un assistant, monsieur Murray Ross. Tous deux sont des personnes de la plus grande valeur et il faut les payer. Les fonds manquent. C'est encore là un problème que nous allons étudier sérieusement.

Chaque année, depuis deux ans, le Conseil des Hôpitaux du Canada décerne des décorations à des personnalités marquantes dans le domaine hospitalier. Le premier à recevoir ces décorations a été le docteur A. K. Haywood, de Vancouver. Vous connaissez bien le deuxième: le docteur Fred Routley, de Toronto, qui nous a quittés pour monde meilleur. Cette année, nous aurons le plaisir, et pour moi, c'est un réel plaisir, de décorer quelqu'un que nous considérons commes l'ami de tous, mais que, en plus, je considère comme un ami personnel, nous allons décorer, dis-je, le docteur Gilday.

Il sera question, au cours de ces réunions, d'un projet de centralisation des hôpitaux. C'est un projet de grande envergure et l'heure est grave. Il faut savoir où nous allons. Persons y bien et sachons apporter notre part à la discussion.

Je pourrais parler longuement de la construction, mais je crois que le point le plus important est l'assurance-chômage. Depuis quelques années, il s'est fait une pression à Ottawa, pour inclure les employés d'hôpitaux dans l'assurance-chômage. Jusqu'à date, les dirigeants des hôpitaux se sont opposés à cette mesure. Allons-nous garder cette ligne de conduite?

L'on vous offre actuellement un cours par correspondance sur l'administration des hôpitaux. Comme nous allons discuter de la valeur de ce cours cet après-midi, je n'en dirai pas davantage.

Je termine ce résumé en imitant peut-être un peu monsieur Armstrong, qui a fini sur une note sympathetique, en disant que le Président, à son départ du Conseil, laissait de nombreux amis derrière lui, qu'il avait grandement profité de ses réunions, de ses rencontres avec le Conseil. Je suis assuré que monsieur Armstrong était sincère dans l'expression de ces sentiments qui sont les miens et, je n'en doute pas, ceux de chacun de nous, qui travaillons avec le Conseil des Hôpitaux du Canada. Merci.—*R. Père Hector L. Bertrand, S.J.*

# Novel Features Noted at New "K-W" Hospital

IT was a gala day in the twin cities, Kitchener and Waterloo, Ontario, when on May 24th the new "K-W" hospital was opened. After the official ceremony, performed by the Governor-General, Viscount Alexander of Tunis, guests from many Canadian cities, from the United States, and crowds from its own area were enabled to view the hospital and examine its many exceptional features.

Individuals and organizations in the vicinity have a large investment in this 347-bed institution. A year ago a "citizens committee" undertook to furnish and equip patient rooms, as well as operating and delivery rooms, through donations; and public response has made possible the finest in labour-saving devices and equipment.

The spiritual aspect of hospital care is emphasized in the decoration of the beautiful entrance lobby. Here, on pillars finished in dark blue, an artist has depicted in white the story of the Good Samaritan. A small but elegant chapel has likewise been provided and, by means of pillow ear phones, patients will be able to listen regularly to religious services.

### "Hi-Lo" Beds

Each patient will luxuriate in a "high-low" or push-button bed. Touch the button and the bed is lowered from the high position convenient for the nurse or doctor to a position near the floor. This innovation encourages early ambulation since the patient can so easily get out of bed and it also lessens the hazards of accidental falling.

Rooms are one-bed, two-bed, or four-bed in size and in the total capacity there is one-third of each type. Curtains in attractive floral designs extend across the exterior wall of each room and can be drawn across the windows as desired. These can be laundered readily. Walls are painted in softly contrasting pastel tones. The rooms are lighted by indirect urn fixtures above each bed. The latter are tri-lights of 100, 200, and 300 watts, and can be controlled by the patient.

No bureau or dresser, so often used only as parking space for flowers, is found here. There is a simple table which can be used for the above purpose or as a writing desk for the ambulant patient. More important is the bed-side table-cum-chest. Built of limed oak with plastic top, this item has a top drawer which can be drawn two ways—by the patient or, on the outer side, by the nurse. It has a shelf for magazines, pull-out leaves in two positions for use when the bed is up or down and, in the lower section, doors open to reveal an extra blanket and pillow. While the chest was built to specification for the hospital, we understand that it will, henceforth, be available for any institution.

Each patient also has an over-bed table of steel, finished in a blonde tone. This accommodates a tray or opens up for use as a book-rack, has a make-up mirror with space for cosmetics, and a stationery section. The "super-loafer" adjustable steel frame chair, with or without castors, encourages the patient to leave even a "high-low" bed. Clothes cupboards or individual lockers have also been installed.

### Combination Bassinet and Cabinet

In the pink and robin's egg blue nurseries, with partitions of glass

and steel, each cubicle is fitted with a combination cabinet and bassinet, complete in one unit. This arrangement, designed by the superintendent, Gordon A. Friesen, and his colleagues, is one of the hospital's original features.

The cabinet contains a wash basin which can be rested on a swivel hoop mounted within, shelves for clean linen, and a second swivel hoop from which can be hung a hamper for soiled linen. Inside the door is a small rack for oil, cotton, et cetera. The bassinet is of plastic and can be swung out from its place on top of the cabinet to allow work space for bathing. The whole unit, complete with infant, can readily be wheeled to the mother's room and kept there as long as desired. Equipment of this type conforms with the "lying-in" principle toward which there is a current trend.

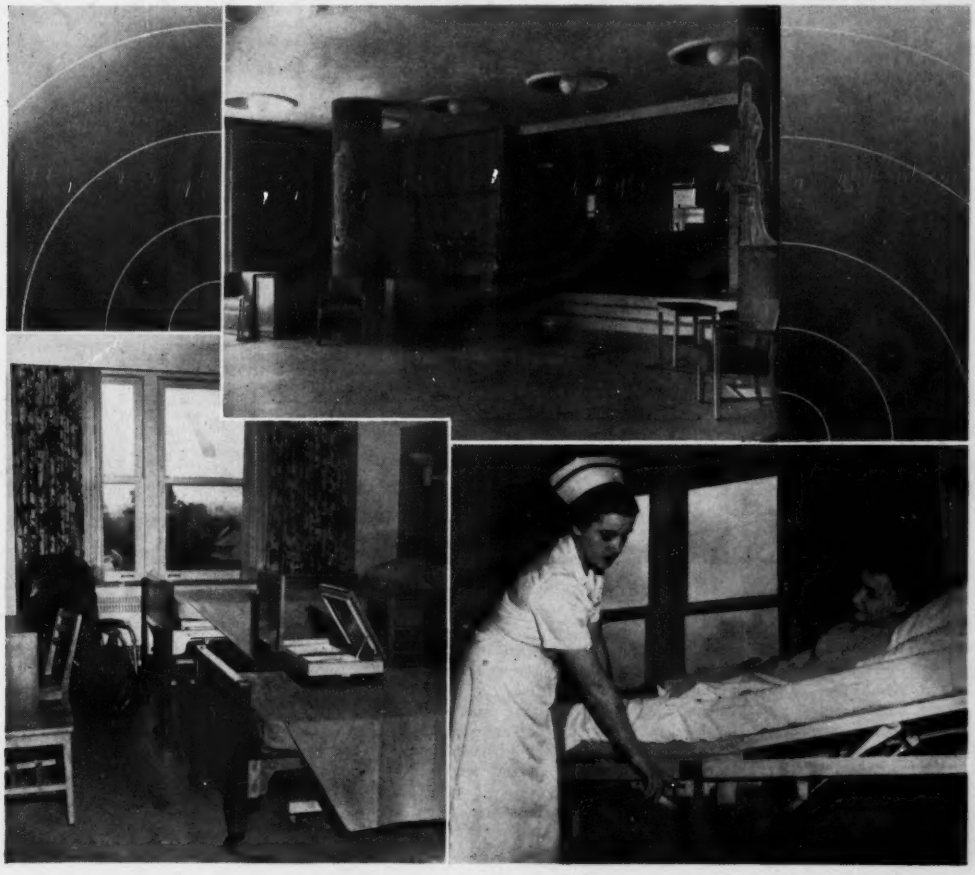
Expectant fathers will not stalk the corridors and generally get under-foot. Comfortable lounges, furnished for them by the Scots Fusiliers, have pacing space, easy chairs, and jumbo-sized ash trays.

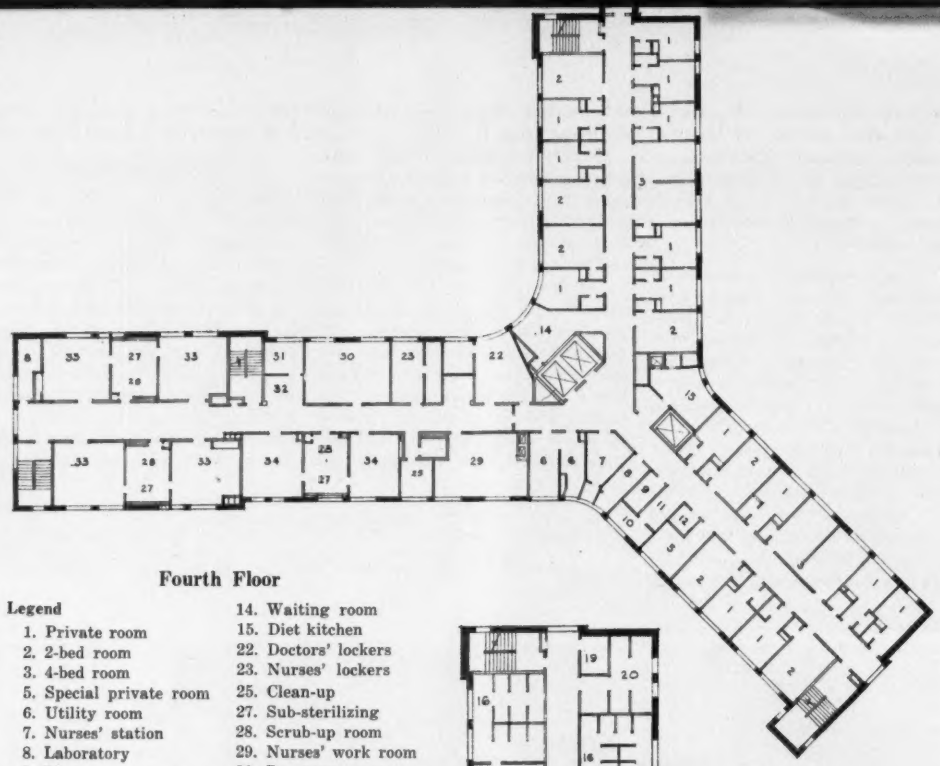
The children's floor, plan of which appears with this article, is not yet completed but, when opened, will feature glass partitions so that nurses can have a clear view of their young charges at all times. This section will have its own "radio" band over which a nurse can tell bedtime stories from her station. All furnishings are being donated by the K-W Rotary club at a cost of $35,000.

### No Laundry Chutes

The system of distributing and storing linen is again something different at the "K-W". There are no built-in linen cupboards in the nursing units and no laundry chutes. Each day a truck takes all linen required for a unit to a large closet on the floor and there it stands while in use. It also has large hampers on hoops for soiled linen. Under each bed is a smaller swivel hoop to which is attached an individual laundry bag. The nurse tosses soiled linen there;

*Centre: Oak-panelled main rotunda. Murals on pillars depict the story of the Good Samaritan.*
*Left: A two-bed room. Note over-bed table and bed-side table-chest with pull-out leaves. Table tops are of laminated plastic.*
*Right: The nurse adjusts the "high-low" bed by simply pressing a button.*





## Fourth Floor

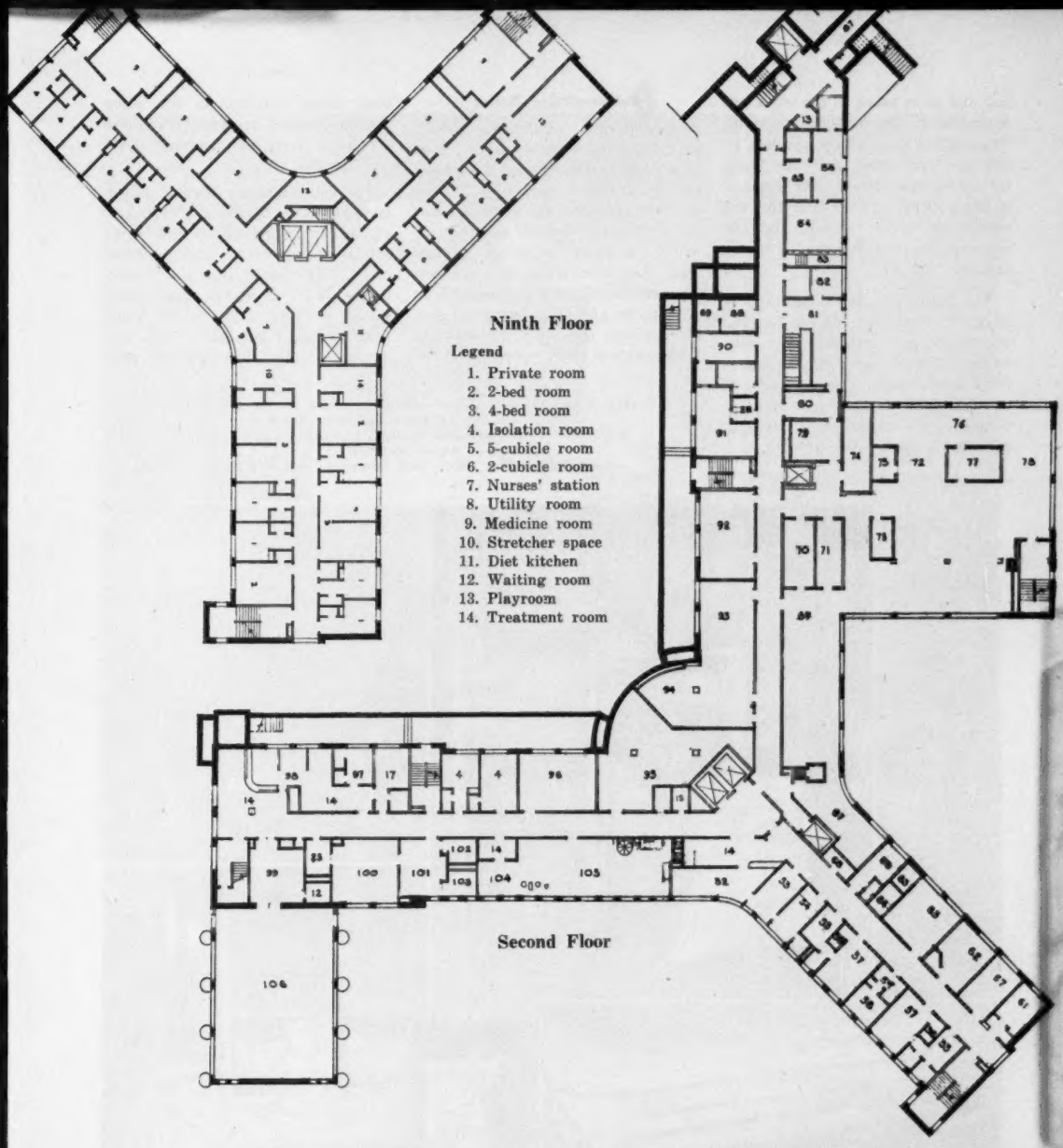
**Legend**

1. Private room
2. 2-bed room
3. 4-bed room
5. Special private room
6. Utility room
7. Nurses' station
8. Laboratory
9. Linen
10. Flower room
11. Stretcher space
12. Public lavatory
13. Janitor's closet
14. Waiting room
15. Diet kitchen
22. Doctors' lockers
23. Nurses' lockers
25. Clean-up
27. Sub-sterilizing
28. Scrub-up room
29. Nurses' work room
30. Recovery room
31. Anæsthetic storage
32. Bed storage
33. Major operating
34. Minor operating

## Fifth Floor

**Legend**

1. Private room
2. 2-bed room
3. 4-bed room
6. Utility room
7. Nurses' station
8. Laboratory
9. Linen
10. Flower room
11. Stretcher space
12. Public lavatory
13. Janitor's closet
14. Waiting room
15. Diet kitchen
16. Nursery
17. Examination room
19. Fan room
20. Suspect nursery
21. Milk room
22. Doctors' lockers
23. Nurses' lockers
24. Labour room
25. Clean-up room
26. Delivery room
27. Sub-sterilizing
28. Scrub-up
29. Nurses' work room.




**Legend**

4. Separation room
12. Public lavatory
13. Janitor's closet
14. Waiting room
17. Examination room
25. Clean-up room
28. Scrub-up room
52. Reception
53. Film viewing
54. Radiologist
55. Dressing room
56. Control
57. Radiographic
58. Dark room
59. Wet film viewing
60. Deep therapy
61. Superficial therapy
62. Cystoscopy room
63. Fracture room
64. Splint room
65. Plaster room
66. Female rest room
67. Dish sorting
68. Stores
69. Main servery
70. Holding refrigerator
71. Dairy refrigerator
72. Main kitchen
73. Dietitian's office
74. Kitchen stores
75. Meat refrigerator
76. Fruit and veg. preparation
77. Fruit and veg. refrigerator
78. Bake shop
79. Pasteurizing plant
80. Bottle wash
81. Receiving entrance
82. Receiving office
83. Gallery
84. Autopsy
85. Museum
86. Morgue
87. Tunnel
88. Can storage
89. Garbage refrigerator
90. Truck washing
91. Formula room
92. Dish washing
93. Employees' dining room
94. Preparation room
95. Storage
96. Unassigned
97. X-ray
98. Admitting office
99. Entry
100. Emergency operation
101. Emergency hall
102. Doctors' lavatory
103. Nurses' lavatory
104. Pharmacy office
105. Pharmacy
106. Ambulance entrance

bag and all is taken to the truck and deposited in the hampers provided. Thus soiled linen is not touched by any employee other than the nurse caring for the patient. At mid-day, a fresh truck arrives and the one containing laden hampers and any left-over supplies is returned to the laundry.

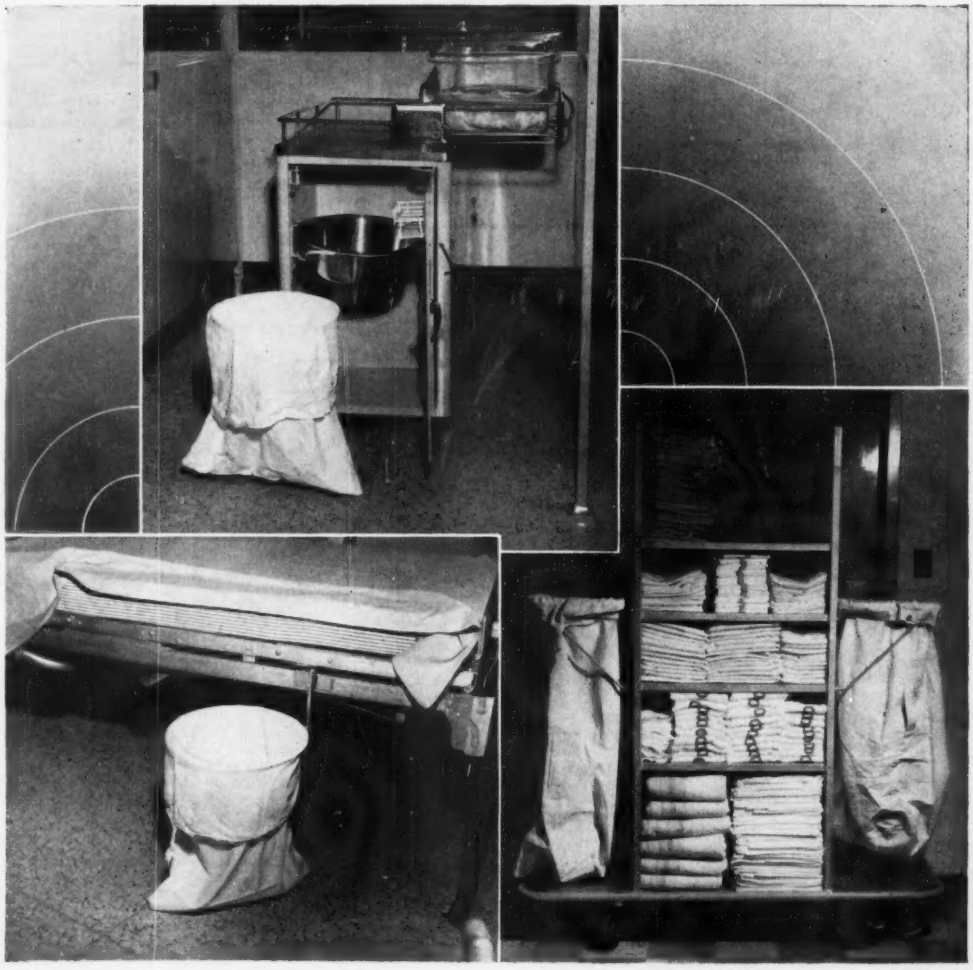
The latter department, which is in a newer section of the old hospital (connected by corridors), has been in operation for some months and is fully mechanized. The capacity of its mammoth machines is so great that two other hospitals in the area are able to use it also.

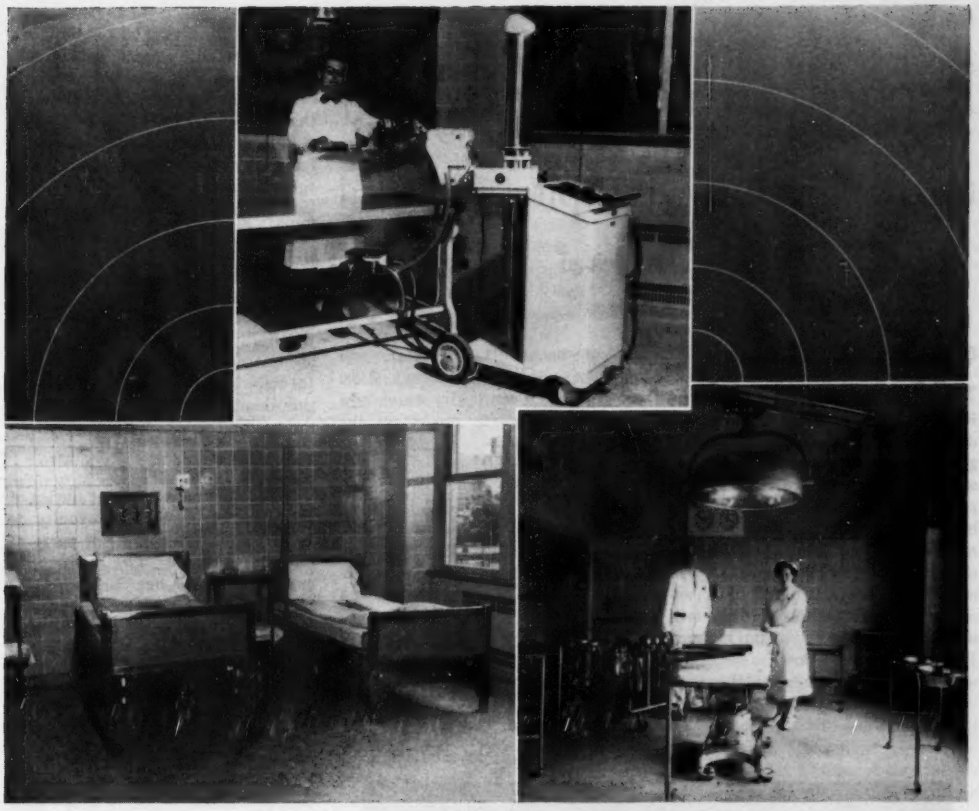
**Sub-Sterilizing Rooms**

One of the outstanding breaks with tradition in this hospital is to be seen in the layout and equipment of the sub-sterilizing rooms. Here the sterilizing section has direct entrance from the corridor and the surgeon's "scrub-up" is on the exterior wall. Hence surgeons view proceedings connected with sterilization as they go in and when scrubbed step directly into the O.R. All ordinary traffic stops at the first section. Moreover, mops required in the damp scrub-up section are kept right there and not in some dark cupboard down the corridor.

The sub-sterilizing section proper has only three pieces of equipment: (1) a thermostatically controlled, insulated, solution and blanket warmer; (2) emergency instrument sterilizer; (3) insulated instrument washer-sterilizer. The "K-W" is the first Canadian hospital to use this layout and the first hospital any-

*Centre: Combination bassinet and chest which can be moved to the mother's room at will.*
*Left: There are individual laundry hampers on swivel hoops under each bed.*
*Right: Laundry truck with hampers for soiled linen.*





*Centre: The mobile fluorscope and x-ray unit with specially designed curved arm.*

*Left: A corner of the recovery room.*

*Right: An operating room.*

where to have the latter two models in sterilizing equipment. For further information on this topic see page 52. All other sterilization is carried out in the central sterile supply department, layout of which was shown in the May issue of this journal.

**Fracture Room**

The fracture room, which is part of the elaborate radiological department, has equipment particularly designed for it. The fracture table proper is made of aluminum and the top is impervious to plaster and other materials which are used here. Beneath the metal table top is a 20 milliampere, self-contained, x-ray machine measuring 16 by 7 by 14 inches. This machine is powerful enough to provide fluoroscopy and spot film radiograph, and is provided with ray-proof shutters which are accessible from the operating side of the table.

A red light is so arranged on this table that connection is made to the x-ray footswitch so that when the operator has the x-ray on the red light is off and, when the x-ray is off, the light is on to illuminate the working area without affecting the dark accommodation of the doctor's eyes. The fluoroscopic screen is not suspended from the ceiling as in conventional arrangements. It is supported on a mobile stand and can be moved out of the way when not required.

A mobile fluoroscope and x-ray unit is a special feature of this room. The unit has a semi-circular arm supporting a screen at one end and x-ray tube at the other. A tiny motor mechanism permits push-button control to direct the fluoroscopic beam vertically or horizontally. This machine is invaluable in the complex operation of hip-nailing and takes the place of having two mobiles, as are commonly employed. The unit can be used in conjunction with any table whose surface is not opaque to x-rays and is moved to and from the major operating rooms and the orthopædic department.

**Laboratories**

An up-to-the-minute laboratory has a staff of 14 in all, including five students in-training. Besides hospital work, milk and water tests for the area are carried out here for the provincial government, under a full-

*(Concluded on page 78)*

# Report of the Secretary to the Canadian Hospital Council

**Ottawa, May 28-30**

MR. PRESIDENT, the Honourable the Minister of National Health and Welfare, Reverend Fathers, Reverend Sisters, distinguished visitors, ladies and gentlemen. It is my privilege to present the report of the Executive Secretary to the delegates gathered here for this the eleventh biennial meeting of the Canadian Hospital Council. Because this report covers a two-year period, it might have presented some difficulties, for my tenure of office has been but ten months. Fortunately, my close association with Professor Agnew at the University of Toronto before joining the Council and the addition to the staff of the assistant secretary and associate editor, Mr. Murray Ross, has provided a continuity which now permits a complete report on the period just ended.

### Expansion of Activities

The decision taken at the 10th biennial meeting in Quebec City in May, 1949, that the Canadian Hospital Council should expand its activities to match the growth and meet the needs of the Canadian hospital field, is now reflected in larger facilities and staff on duty today. The foresight of my predecessor permitted us to add additional space on the same floor of our present building, so that council offices now occupy the entire third floor of the building. With this badly needed space available, it has been possible to nearly double the size of the library, more than double the space for the Journal staff and at least triple the administrative area. We now have enough room to develop a broader educational program. The executive staff has been increased from one to three full-time men, the secretarial and clerical staff from 2½ to 4½ persons, while the Journal has been maintained at 5 full-time persons, and the library at 1½ persons. It has been necessary of course to add office furnishings and equipment. All of this should permit a wider service to the hospital field.

*Enjoying a little relaxation between busy session of the C.H.C. biennial meeting are, standing left to right: R. Fraser Armstrong, Kingston, Ont.; Dr. A. L. C. Gilday, Montreal; and Dr. R. Lemieux, Quebec. Seated, left to right: Dr. Harvey Agnew, Toronto; Andrew Pattullo, of the W. K. Kellogg Foundation, Battle Creek, Mich., and Dr. L. O. Bradley, Toronto.*

### Visiting the Field

One of the most pleasant duties of this position is the opportunity to visit hospital people in all parts of Canada. Not only does one develop many fine friends but one is also able to put an ear to the ground and pick up the opinions and attitudes of a wide cross-section of our hospital people. Since the 1949 meeting in Quebec Dr. Agnew visited all provinces except Newfoundland. Mr. Ross has participated in several meetings in Quebec and the Maritimes and will cover the western part of Canada, which he knows well, before this year ends. It is going to be possible for me to attend each provincial or regional association meeting and several conferences before the end of my first year of service. And if all goes well, it seems possible that a trip to Newfoundland might be arranged before the end of August. It may be naïve for me to say so, but it has been constantly amazing and always stimulating to find so many people in so many places so filled with enthusiasm for their field of service.

As the months and years go along, as our work takes us to different areas of Canada, and as time and finances permit, Mr. Ross, Mr. MacIntyre and I hope to see many individual hospitals as did Dr. Agnew during his service in this cause.

### Advisory Service

Although the advisory service of the Council is probably the least

*(Continued on page 72)*

# Greetings by the Business Manager

*Mr. President and Hospital Friends:*

A WRITER in one of the popular magazines some time ago had a series of stories in which the central figure was a somewhat shiftless but rather engaging southern boy by the name of Florian Slappey. Now Florian had a weakness for getting into hot water, and one of his recurring expressions was: "Troubles, boy! Troubles is something I ain't got nothin' else of but". Unfortunately, you hospital people assembled here also have troubles and problems most of which, I submit, are not of your own making.

Fortunately, the problems of publishing do not concern many of you to any great extent, and I do not propose to introduce any at this time. Briefly, we believe that the journal is growing in prestige and service, and may I remark at this time that no matter how many other nice things are said of Dr. Harvey Agnew, I wish to acknowledge the great contribution he has made and is still making to the journal. I have been very closely associated with him during all of the twenty years since the Canadian Hospital Council was founded.

Increased production costs have greatly concerned us during the past year. Printers have an unhappy knack of raising their prices faster than we can increase our advertising rates. If I appear to be somewhat out of breath at the moment, it is because they keep me running so fast, just trying to keep up with them.

We now have a new team in the Council—Dr. Leonard Bradley and Mr. Murray Ross — enthusiastic, capable and hard-working. I can assure you that they, together with our tried and true Miss Jessie Fraser, have new ideas popping all about the place.

Our circulation has increased by almost 50 per cent during the past few months. This, to some extent, represents a service on the part of the journal inasmuch as the subscription revenue does not entirely cover the total cost of printing and mailing these extra copies. We believe, however, that we should have a very extensive distribution of the journal in the various departments of the hospital and, in this way, widen our sphere of usefulness to hospital workers.

May I extend best wishes to you during this eleventh biennial meeting of the Canadian Hospital Council. May you find many happy solutions to the problems in hospital administration which confront you, and many and sincere thanks for your wonderful co-operation throughout the years.—*Charles A. Edwards.*

* * * *

## Un Revue des Rapports

C'est à moi qu'incombe le privilège de passer rapidement en revue le rapport du Secrétaire exécutif et les observations faites par monsieur Edwards.

En passant en revue les activités du Conseil depuis la dernière assemblée plénière, le docteur Bradley a mentionné que chaque région du Canada avait reçu la visite des membres du secrétariat. Il a souligné que c'est une tâche aussi agréable qu'utile que de prendre part à des réunions régionales, de faire la connaissance de nos amis là-bas, et d'écouter ce qu'ils ont à nous dire.

Ainsi qu'il fut décidé lors de la Dixième Assemblée biennale, qui eut lieu à Québec en mai 1949, les activités du Conseil des Hôpitaux du Canada prennent une extension progressive. Nous avons augmenté notre personnel, agrandi nos locaux, et acheté l'équipement voulu.

En nombres toujours croissants, les hôpitaux mettent à contribution le service consultatif du Conseil, et l'on consulte de plus en plus souvent la bibliothèque de référence.

Le Conseil a fait un grand pas en avant en mettant sur pied un cours d'organisation et d'administration hospitalière de deux ans avec l'aide de la Fondation W. K. Kellogg. Comme vous l'aurez vu à l'agenda, nous entendrons parler de ce cours plus en détail durant l'Assemblée, par le docteur Agnew, président du Comité de l'Education, et de monsieur Pattullo, représentant la Fondation.

Le docteur Bradley a fait allusion aux liens étroits qui nous unissent avec l'Association Médical canadienne, en ce qui concerne l'étude des problèmes qui intéressent à la fois les hôpitaux et le corps médical.

Vous n'ignorez pas que jusqu'à présent, nous avons réussi à empêcher que le personnel des hôpitaux tombe sous la loi de l'assurance-chômage. Il se peut que l'Assemblée examine également cette question un peu plus tard.

Tous, nous déplorons que l'espoir dont nous nous berçions il y a environ cinq ans—espoir d'une paix durable dans le monde-semble chaque jour plus irréalisable. La défense civile et les préparatifs en cas de danger national ou de calamité publique mettent lourdement à contribution votre personnel. Pourtant, vous comprendrez qu'il est très important, surtout à notre époque si troublée et pleine d'incertitudes, de coordonner le fonctionnement des hôpitaux avec celui des organismes volontaires et gouvernementaux, et de veiller à la protection de leurs intérêts et de leurs droits.

Parmi les réalisations les plus importantes du Conseil et parmi ses tâches les plus ardues, nous pouvons classer la publication de la revue hospitalière nationale, "The Canadian Hospital". Le docteur Bradley a attiré votre attention sur le labeur de direction réalisé par le docteur Agnew, qui a amené le niveau éditorial de ce journal à un très haut degré d'excellence; il vous a affirmé aussi que nous nous efforçons tous de maintenir cette haute tenue et de permettre à la revue de poursuivre sa marche ascendante.

Notre revue en est à sa vingt-huitième année. Voici déjà plusieurs années que son fondateur, monsieur Charles Edwards, passa au Conseil les droits de publication, mais il n'a jamais cessé de nous accorder son appue, et nous lui en sommes aincèrement redevables.

En parlant lui-même du journal, monsieur Edwards a signalé un accroissement de la circulation, et un progrès général. Il a mentionné quelques-unes des difficultés auxquelles nous devons faire face en

*(Suite en page 100)*

# *Camera Comments on*

There was a large attendance when Prime Minister St. Laurent received delegates in the Railway Committee Room at the Parliament Buildings.

In this group are, left to right: John R. Marshall, president, O.H.A.; Edith Young, Ottawa Civic Hospital; Agnes MacLeod, Department of Veterans Affairs, Ottawa; John N. Hatfield, past president of the A.H.A.; George Bugbee, executive secretary, A.H.A.; Edgar Dutton, Galt Hospital, Lethbridge, Alta.; and Frank Swain, High River Municipal Hospital, High River, Alta.

Smiling for the camera are, left to right: Irene Olynyk, Women's College Hospital, Toronto; Frank Silversides, Children's Hospital, Winnipeg; and Mary Asquith, Stratford General Hospital, Stratford, Ont.

The ladies were well represented at the meeting. In this picture are, left to right: Martha Nephew, Cornwall General Hospital, Cornwall, Ont.; Mrs. J. A. Aylen, Ottawa; Mrs. T. J. Lytle, Toronto; Edith G. Young, Ottawa Civic Hospital; Myrtle Lambert, Cornwall General Hospital; and Marjorie Goodfellow, St. Lawrence Sanatorium, Cornwall.

The panel of experts who addressed the Assembly on preparedness for national emergency or disaster were, left to right: Dr. W. S. Stanbury, Canadian Red Cross Society; Col. J. N. B. Crawford, Department of National Defence; Dr. K. C. Charron, Department of National Health and Welfare; and Major-General F. F. Worthington, co-ordinator of Civil Defence.

# *C.H.C. Meeting*

A typical scene at the busy registration desk.

Pictured at the head table are, left to right: Dr. L. O. Bradley, Father Hector L. Bertrand, Mrs. Armstrong, R. Fraser Armstrong, Mrs. Gilday, Dr. A. Lorne C. Gilday, Mrs. Hughes, Jean Lesage, M.P., and H. G. Hughes. The graceful Italian figurine, which can be seen on the table, was presented to Dr. Gilday, when he received the George Findlay Stephens Memorial Award.

Chatting together are, left to right: Ocean G. Smith, Toronto; G. W. Myers, Regina; George N. Barker, Toronto; Dr. F. B. Roth, Regina; and F. G. Smallwood, St. John's, Newfoundland.

Exchanging pleasant smiles are, Dr. Harvey Agnew, Toronto, and Ileen Kemp, Hamilton, Ont.

Posing for the camera are, left to right: A. Fraser Moffatt, Ottawa Civic Hospital; Dr. E. Gordon Wride, Ottawa; R. J. Weatherill, St. Catharines General Hospital, St. Catharines, Ont.; Dr. R. J. Dolan, Saint John, N.B.; and Neil MacLean, Charlottetown, P.E.I.

# *A Brief Review of*

# Federal Health Services

**Part I**

**F. W. Rouse,**
**A/Director,**
**Information Services Division,**
**Department of National Health and Welfare,**
**Ottawa.**

WHEN the original provinces united at Confederation, responsibility for health stewardship as between local and provincial authorities was defined only broadly—and welfare not at all. It was quite natural that, in 1867, the many complexities of modern living were not visualized. As a result, Canada's constitution—the British North America Act—did not provide for the multiplicity of services now demanded by the conditions of modern living and by the citizens who must live under these changed conditions.

Nevertheless, successive national and provincial administrations have been able through the intervening years to erect a wide and efficient health and welfare structure without overlapping.

Generally speaking, treatment and health services have remained the primary responsibilities of the provinces, as was intended at Confederation. However, the federal authority, in addition to its constitutional role of guarding against importation of disease and its spread in Canada, has added numerous services, extending leadership and assistance to provincial and local authorities in their problems.

The line between health and welfare being almost indefinable, development of social services has kept pace with those established to advance and maintain health standards.

Over the years federal, provincial and local authorities, ably supported by voluntary agencies, have achieved much and aim at ever higher standards. Public health specialists, the medical and allied professions, scientists, social workers, and interested groups of citizens have been enlisted to strengthen health security and to improve conditions. Already many objectives have been attained in the co-ordinated assault on disease, distress and destitution.

The federal government, in this generation, has played a major role in the integration and direction of all forces striving in the welfare field. By inspiration and liaison, by research and by underwriting worthwhile activities on the part of innumerable socially-minded interests, it has stimulated and co-ordinated an expanding movement to improve the lot of Canadians. Notably, it has operated in the field of welfare through Family Allowances, consisting of direct grants, based on age and number in family, to all children under 16 years of age; has paid 75 per cent of the basic Old Age Pensions,* in a dominion - provincial plan which provides assistance, subject to a means test, to all persons 70 years of age and to the blind at 21 years; and has worked with and through the provinces in a Physical Fitness Program, to encourage and promote fitness by stimulating interest and participation in all forms of recreational activity.

### National Services

One of the leading groups in the fight for better health is the advisory body known as the Dominion Council of Health. This council is composed of a chief health officer from each province, with representatives of science, labour, agriculture, and English and French-speaking women's organizations, under the chairmanship of the deputy minister of national health. It discusses and evaluates health activities; and many important measures stem from its recommendations to the federal minister of national health and welfare.

Then, the federal department has certain statutory functions. For instance, its immigration medical, quarantine and sick mariners' services include the health examination

*The quarantine station at William Head, B.C.*

**This article was written prior to the recent announcement concerning the granting of pensions without a means test. Payments without a means test to all persons 70 or over is now referred to as "old age security" while the term "old age pensions" will apply to the means test program involving the 65-69 age group.*

of all prospective immigrants, inspection of all vessels and aircraft arriving in Canada (in order to prevent the entry of those with infectious disease), and free medical and surgical treatment up to one year for all members of crews of those vessels calling at Canadian ports which have paid the stipulated dues. It also looks after the administration of leprosaria for the few leprosy cases in Canada. The food and drug control divisions, with administrative and laboratory facilities, maintain standards for imported and domestic consumables and pharmaceuticals.

The control of narcotic drugs is handled by the department, with the Royal Canadian Mounted Police acting as the enforcement agency. Public health engineering services work to ensure sanitary conditions of international boundary waters, to guard against pollution of shellfish areas, to preserve purity of food and drink on trains, ships, and airplanes, and at railway depots. They also maintain environmental sanitation in national parks, at federal projects, including highway and airport developments, and on drainage and land-clearance undertakings.

Indian health services provide ever-increasing hospital, medical, nursing, and dental care to Canada's Indians and Eskimos. A civil service health division makes consultative, counselling, examination, and first-aid services available to federal employees. The federal laboratory of hygiene co-operates with the provincial laboratory services in advancing diagnostic standards and techniques, giving special attention to the study of contagious diseases, including the testing of biological products used in their control or treatment. The civil aviation medicine division, in its capacity as adviser to the air services branch of the Department of Transport, contributes to the establishment and maintenance of sound health and safety factors in relation to flying.

**Assistance to Provinces**

In addition to these statutory services, the Department of National Health and Welfare extends leadership and assistance to the provinces in such varied fields as industrial

*(Concluded on page 80)*

# Les Services de Santé du Canada

LE Canada a droit de s'enorgueillir des immenses progrès qu'il a réalisés au cours des dernières années dans le domaine de l'hygiène et de la santé publiques, qu'il s'agisse de la surveillance des aliments et des drogues, de la lutte, contre le trafic illicite des stupéfiants, de l'hygiène maternelle et infantile, de la lutte contre les maladies contagieuses, de la prolongation de la vie humaine, ou des recherches scientifiques dans le domaine médical.

Ces progrès se sont réalisés grâce à l'esprit d'initiative et à la collaboration de tous les organismes intéressés: gouvernement fédéral, administrations provinciales et municipales, agences bénévoles, à mesure que la population du pays grandissait et que des besoins nouveaux apparaissaient.

Sous plusieurs rapports, le Canada s'est déjà placé à la tête des nations. Quoi qu'il en soit, conscient de ses besoins et de ses ressources, il s'est tracé un vaste programme d'hygiène et de santé publiques qu'il entend développer avec méthode. Les résultats déjà obtenus laissent bien augurer de l'avenir.

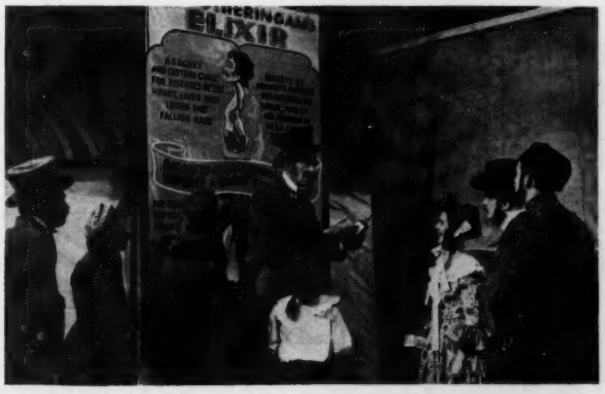
**Services nationaux**

Le Conseil canadien d'hygiène publique constitue l'un des organismes les plus importants dans le domaine de la santé. Composé des sous-ministres provinciaux de la santé, des représentants de l'agriculture, du travail, des organismes féminins de langue anglaise et de langue française, ainsi que d'un conseiller scientifique, il discute toutes les questions qui relèvent de l'hygiène publique et présente ses voeux, en vue de futures initiatives, au ministre fédéral de la Santé nationale et du Bien-être social.

La santé publique au Canada ressortit aux gouvernement fédéral et provinciaux, par l'entremise de leurs ministères respectifs de la Santé.

Le gouvernement fédéral n'a compétence que dans les questions relatives à la santé publiques qui sont exclusivement internationales, nationales et interprovinciales. Ses fonctions statutaires sont les suivantes: maintenir une quarantine de la navigation maritime et aérienne; renseigner le service d'immigration sur la santé des immigrants; fournir les soins médicaux aux marins malades ou blessés qui servent à bord des navires; être responsable du soin et de l'hygiène des Indiens et des Esquimaux; établir les normes et contrôler la qualité des aliments et des drogues; régir l'importation, la distribution et l'exportation des stupéfiants; voir au soin des lépreux; veiller à la sauvegarde de la santé des employés de l'Etat; appliquer la loi des spécialités pharmaceutiques ou médicaments brevetés; veiller à la salubrité des eaux limitrophes et au respect de l'hygiène sur les trans-

*(Suite en page 98)*




*—Photos courtesy National Film Board.*

*The medicine man and his quick cures are now a thing of the past.*

# Maritime Hospitals Convene at St. Andrews, N.B.

OVER 300 delegates, representing 104 hospitals in the four Atlantic provinces, gathered at lovely St. Andrews by-the-Sea, from June 4th to 7th, for the ninth annual convention of the Maritimes Hospital Association. A well-planned program, excellent addresses, and spontaneous and enthusiastic discussion from the floor, all contributed toward making the convention a highly successful event.

President Alex D. McInnes presided over the general sessions of the meeting and co-chairmen of the program committee were secretary-treasurer, Mrs. Gladys M. Porter, Kentville, N.S., and Rev. Sister Catherine Gerard, Halifax. They were ably assisted by Dr. C. M. Bethune, superintendent of the Victoria General Hospital, Halifax; and Dr. C. J. W. Beckwith, superintendent of the Halifax Tuberculosis Hospital.

Meeting concurrently with the hospital association were the Maritime Hospital Aids Association (whose meeting is reported on the Auxiliary page of this journal), and the Maritime Hospital Exhibitors' Association. The exhibitors, representing some 50 firms, displayed a wide variety of hospital equipment and supplies, and contributed a very interesting feature to the convention.

In his presidential address, Mr. McInnes spoke of the current nursing shortage and expressed the belief that federal grants to be used toward construction of nurses' residences would soon be made available. The secretary-treasurer, Mrs. Porter, reported that several new hospitals, including some in Newfoundland, and D.V.A. institutions, had become association members during the year.

*On the steps of the Casino, Dr. L. O. Bradley, executive secretary, C.H.C. (left), chats with the new chairman of the Committee on Accounting and Statistics, Walter Dick, Moncton, N.B.*

*A. D. McInnis, Antigonish, N.S., retiring president (left), turns over his office to Neil MacLean of Prince Edward Island Hospital, Charlottetown, in-coming president.*

### Trustees

Speaking on "What the Hospital Trustee Should Know About His Hospital", John M. Storm, Editor of *Hospitals*, outlined various aspects of the hospital such as its nature and purpose, legal liability, and moral obligations to patients. He pointed out the relationships the board of trustees should maintain with the administrator, medical staff, and community. He also called for a program of reform in trusteeship, stressing that although there are many individual trustees who have "gone far beyond the norm" to make a worthwhile contribution, there are others who have not bothered to learn what their own hospital is trying to do and what its problems are.

After Mr. Storm's address, an open forum on trustee-hospital relations was led by Dr. D. F. W. Porter of Moncton, N.B.

### Sectional Meetings

One morning of the convention was devoted to meetings of the three provincial sections, where matters of a provincial nature were discussed. The New Brunswick section decided to ask the provincial government to increase Workmens' Compensation Board payments to hospitals to an amount equalling the present higher costs of treatment for Board patients. The Chairman, Dr. D. F. W. Porter, superintendent of the Moncton Hospital, reported that the government had decided to increase the grant to the public hospitals of New Brunswick to 50 cents per patient day. The Nova Scotia-Newfoundland section appointed a legislative committee to approach the provincial department of health to ask for increased grants for indigent patients and an increase in per diem and Workmens' Compensation Board rates.

### Nursing Shortage

Addressing the convention on the shortage of nurses, Dr. L. O. Bradley, Executive Secretary of the Canadian Hospital Council, urged the formation of committees on local, provincial, and national levels, representative of all affected groups, as a means of solving the shortage. He called for financial assistance from provincial governments but stressed that no government will take action until it is sure that it has the approval of the public at large.

### Good Hospital Service

An address on the essentials of good hospital service was presented by Dr. C. M. Bethune, superintendent of the Victoria General Hospital, Halifax. "The problem of providing good hospital service", Dr. Bethune pointed out, "is a complex one that requires a plan based on broad principles and flexible enough to adapt itself to changes in its requirements and to advance with the progress of medicine." He stressed that the real essential of good service lies within the personnel of the hospital—in the individual employee's integrity and idealism. "The highest of distinc-

tions," he said, "is service to others." Dr. Bethune also emphasized the importance of refresher courses and short training programs for hospital personnel.

**Blue Cross Program**

Considerable discussion developed during the session devoted to the Maritime Hospital Service Association concerning the exorbitant rates which some Maritime hospitals have been charging Blue Cross for patients covered by the Plan. This practice, Blue Cross officials told the gathering, was causing a heavy additional burden on the Plan's finances. As a result, the Maritime Hospital Association passed the following resolution, moved by Dr. O. C. MacIntosh, Antigonish, N.S., and seconded by Father A. A. Beaton, Sydney, N.S.: "Resolved that the Maritime Hospital Association authorize and request that the executive of the Martime Hospital Service Association after careful and considered investigation and negotiations with offending hospitals concerned, when confronted with the problem of a hospital making exorbitant charges for patients, and other abuses, first notify the executive of the Maritime Hospital Association and, failing remedial action from the Maritime Hospital Association, after three months, that the Blue Cross Plan give notice to the offending institution of cancellation of contract." It was pointed out by J. F. H. Teed, K.C., Saint John, that, under the law, cancellation of contracts could not take effect until 13 months after notification was given.

On motion of Father M. J. McKinnon, Glace Bay, N.S., it was decided to set up a hospital advisory committee to carry out the original motion and to help work out other mutual problems. The committee will consist of six members, three appointed by the hospital association and three by the Maritime Hospital Service Association. Named to represent the hospital association were Dr. D. F. W. Porter, Moncton, Chairman; Dr. O. C. MacIntosh, Antigonish; and Rev. Sister Catherine Gerard, Halifax. On a further motion by Father McKinnon, the new group was also instructed to study the possibility of establishing a uniform charge for anæsthetic materials, and dressings.

This session was presided over by Dr. J. A. MacDougall, Saint John, member of the executive committee of the Maritime Hospital Service Association, in the absence of Dr. J. A. McMillan, Charlottetown.

**Planning for Disaster**

Of vital interest and concern to all delegates was the session devoted to planning for disaster. Dr. F. A. McGrand, and Colonel A. B. De Wolfe, chairmen, respectively, of the New Brunswick and Nova Scotia civil defence committees, outlined what had been done to fit the two provinces into the national civil defence organization. Col. De Wolfe reported that plans are being made to stockpile a certain amount of medical stores in different parts of Nova Scotia, as well as to set up a satisfactory air raid alarm system.

Dr. McGrand indicated that good progress is being made in compiling the number of extra mattresses and blankets, and other necessities that could be used to aid in setting up emergency hospitals in church halls, schools, et cetera.

**Other Features**

"Incorporating New Concepts in a Hospital Plan" was the topic discussed by H. Gordon Hughes, Chief, Hospital Design Division, Department of National Health and Welfare, Ottawa. George Fairlamb, Vice-President, O.E.M. Corporation,

*(Continued on page 88)*

*Above from left to right: (a) Sister Margaret Clare, Halifax Infirmary, Halifax; Dr. G. E. Matthews, Victoria General Hospital, Halifax; and Dr. O. C. MacIntosh, St. Martha's Hospital, Antigonish.*

*(b) Dr. A. M. Clark, Department of Health, N.B., and Dr. D. F. W. Porter, Moncton General Hospital, Moncton.*

*(c) Miss M. K. Miller, Victoria General Hospital, Halifax; Major M. Crolly, Grace Hospital, St. John's, Nfld.; and Miss M. E. Hartlen, Queens General Hospital, Liverpool, N.S.*

*(d) Mrs. H. A. McCory, Westville, N.S.; Sister Mary David, Charlottetown Hospital, Charlottetown; Sister Marie de Lourdes, St. Joseph's Hospital, Saint John, N.B.; and Sister de Paul, St. Joseph's Hospital, Saint John.*

*(e) Rev. A. A. Beaton, St. Rita's Hospital, Sydney, N.S.; E. C. Armstrong, Victoria Public Hospital, Fredericton, N.B.; and John Storm, Chicago, Ill., editor of "Hospitals".*

*University Atmosphere and Facilities Contribute to*

# Successful Western Canada Institute

THE almost frightening quiet of summer had settled over the campus of the University of Alberta last month. Then, suddenly, the silence was broken over the weekend of June 17th with the arrival of over 300 delegates to the 6th Western Canada Institute for Hospital Administrators and Trustees and to the convention of the Associated Hospitals of Alberta.

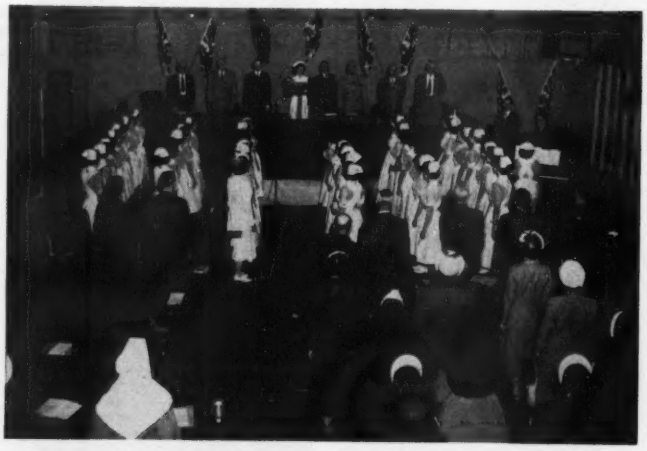
Pembina and Athabaska Halls came to life again as old friends met and renewed acquaintances and as nearly 100 delegates attending their first institute made themselves known to their colleagues from the four western provinces.

On the first day, students gathered in the large lecture hall, filled throughout the week, while Premier Ernest C. Manning extended the greetings of the Government of Alberta and Mayor Sidney Parsons welcomed delegates to the city of Edmonton. Mr. Manning emphasized the importance of public health and preventive medicine, pointing out the role that hospitals must play in bringing a well-balanced health program to all Canadian citizens. At the same time, he warned of the need for preserving an independent spirit of responsibility in health care in order to avoid paternalism in government administration of health services.

After the opening ceremonies, amidst the dignified and academic atmosphere of the university, the stage was set for one of the most successful educational program yet conducted in the west.

Dr. Paul S. Ferguson of the American College of Surgeons led the way into the series of formal lectures by outlining the purpose of the Institute and by describing the problems which arise in a program of hospital standardization and in conducting a medical audit.

The most serious problems in hospital administration today were described by Dr. D. R. Easton of the Royal Alexandra Hospital, Edmonton. He spoke of civil defence, the provision of adequate nursing care for patients in the face of increasing shortages, and the solution of hospital financing problems through the partnership of patient, municipality, and senior government.



*The nurses' choir of the University of Alberta Hospital led the assembly in the National Anthem at the opening of the Institute.*

**Personnel Policies**

The frequency with which the word "personnel" appeared on the Institute program gave emphasis to this aspect of the hospital picture. Graham L. Davis of the W. K. Kellogg Foundation pointed out the guiding principles to be used in planning courses of training for administrators. George Masters, Royal Jubilee Hospital, Victoria, B.C., described the present apprenticeship training programs in operation in British Columbia; and Murray Ross, associate secretary of the Canadian Hospital Council, outlined the new Council extension course in hospital organization and management.

Many other topics relating to good personnel policies were covered. Edythe L. Markstad, University of Alberta Hospital, Edmonton, described an adequate organization for staff health services. The advantages and disadvantages resulting from unionization of employees were cited by James Barnes, Calgary General Hospital, Calgary, Alta. The responsibility of the administrator in personnel management was pointed out by Donald M. Cox, B.C. Hospital Insurance Service. John M. Storm, Editor of *Hospitals* and *Trustee* of the American Hospital Association, suggested that the personnel of the hospital is its best direct link with the community to "tell your hospital's story". Dr. R. E. Bell of Edmonton outlined basic requirements in training laboratory technicians in order to provide a satisfactory level of accuracy in diagnosis. The fundamentals to consider in establishing personnel policies were indicated by Dean Conley, executive director of the American College of Hospital Administrators.

"The Basic Principles of Hospital Organization" was the subject of an excellent address by George Masters. The organization of the medical staff in large and small hospitals was discussed by Dr. H. E. Baird, Regina

General Hospital, Regina, and Leonard Wilson, Drumheller Municipal Hospital, Drumheller, Alta.

In speaking of adequacy without extravagance in hospital administration, Graham L. Davis described plans for co-ordinating hospital, medical, and public health nursing services—a project which the Kellogg Foundation is sponsoring in Michigan. The similarity of the problems there with those predominating in the rural areas of Western Canada made this address of great interest to all delegates.

The valuable contributions of physical medicine in quickening healing processes and hastening rehabilitation were described by Dr. Morris C. Adamson of Edmonton. Dr. Adamson warned, however, that wasted effort must be avoided in using costly therapy in the care of patients whose cure or improvement is not possible.

Medico-legal aspects of hospital operation were covered by Nelles V. Buchanan, K.C., of Edmonton. His presentation, in addition to being most informative, was illustrated by examples described in humourous and entertaining fashion.

The provision of hospital care in the four western provinces was reviewed by Donald M. Cox (British Columbia), Dr. Malcolm G. McCallum (Alberta), Glyn W. Myers (Saskatchewan), and Dr. Owen C. Trainor (Manitoba).

Hospital trusteeship received a good deal of emphasis. John M. Storm gave an excellent address on the need for ideals and self-training; and Judge J. Milton George, K.C., of Morden, Man., reviewed his fifteen years as a trustee. J. M. Morrison, Red Deer, Alta., described the relationship which should be maintained between administrator and trustee, making many practical suggestions whereby the combined efforts of board and management could produce an efficient organization and the highest possible standard of patient care.

Of interest and importance was the address delivered by Herb Bassett of Prince Albert, Sask., who spoke on the admitting officer and her job.

The necessity of adequate accounting procedures received due attention at the Institute. A description of elementary accounting principles was provided by Garnet Hollingshead of Edmonton; the application of these principles to hospitals was outlined by Percy Ward of Vancouver; and the need for costing, to some degree at least, in all hospitals was brought forward by L. R.

*(Continued on page 96)*

# Hospitals of Alberta Convene

Following the Sixth Western Canada Institute for Hospital Administrators and Trustees, the Associated Hospitals of Alberta held its annual meeting at the University of Alberta, Edmonton.

In his presidential address, Edgar E. Dutton of Lethbridge reviewed Association activities during the 8 months since the last convention. As chairman of the Board of Trustees of the Alberta Blue Cross Plan, sponsored by the Association, Mr. Dutton reported continued growth and expansion in Blue Cross coverage and a sound financial position.

Chairman of the economics committee, Leonard Wilson of Drumheller, reviewed the efforts of this important and active committee. The most significant of several recommendations was the suggestion for a considerable increase in basic standard ward rates. These rates have remained static for over two years, and the increases suggested are indicated by rising costs of operation during this period. However the convention took into account the personal recommendation of the committee chairman, that action on the question of rates be deferred pending the outcome of studies currently being made, and referred the matter to the Board of Directors for subsequent review and action.

James Barnes of Calgary submitted the report of the resolutions committee. Unanimous approval was given resolutions of appreciation directed to the University of Alberta; the organizers, directors and faculty; the exhibitors; and the Coca Cola Company. Appreciation was also expressed to the governments of Alberta and of Canada for financial aid extended to hospitals under the national health program.

The economics committee was directed to seek supplementary provincial financial aid for outpost hospitals and to continue efforts to work out with the minister of health a mutually satisfactory definition of a medical indigent.

The Association reaffirmed its stand that hospital services, rendered to patients whose care is the responsibility of the government, should be paid for at the basic rates recommended by the Association for both standard ward care and special services, in each grouping of hospitals in the province.

A resolution, which would have asked the government to share in the cost of furniture and equipment purchased for hospitals by womens' auxiliaries and others, was rejected by the delegates.

Dr. D. R. Easton, chairman, presented the report of the nominating committee and, following the requirements of the constitution, positions on the Board of Directors, economics committee and Blue Cross Trustee Board were thrown open for additional nominations from the floor. Spurred by a desire to ensure adequate representation for small hospitals, a number of additional nominations were made and formal elections were held with all the enthusiasm and spirit of a national campaign. Inasmuch as the annual meeting of the Association took place in June rather than October the new officers will not assume their duties until October 1st. They are:

*Honorary President:* Hon. Dr. W. W. Cross, Alberta Minister of Health.

*President:* Leonard Wilson, Drumheller.

*Vice-President:* Nelles V. Buchanan, K.C., Edmonton.

*Secretary-Treasurer:* L. R. Adshead, Edmonton.

*Board of Directors:* Dr. D. R. Easton, Edmonton; Rev. Sister M. Beatrice, Banff; S. H. Edwards, Bassano; Edgar E. Dutton, Lethbridge; James Barnes, Calgary.

*Economics Committee:* James Barnes, Calgary, chairman; Garnet Hollingshead, Edmonton; S. V. Pryce, Calgary; E. H. Rath, Stettler.

*Blue Cross Trustees:* Frank Swain, High River; Rev. Sister A. Herman, Edmonton; Edgar E. Dutton, Lethbridge.

# Progress Report on C.H.C. Extension Course

THE Committee on Education of the Canadian Hospital Council announces favourable progress in the development of the extension course in hospital organization and management. The following data has been released as a result of conferences held in May during the biennial meeting of the Council.

The program will be directed from the offices of the Council, and the Department of Hospital Administration at the University of Toronto will be responsible for curriculum content and supervision. The activities of the university department and the Council will be guided and co-ordinated by a liaison committee, composed of three Council and three university appointees who will lay down policy and give advice as to the nature of instruction and training needed in this field. Other Canadian universities and a number of hospitals in university centres will be invited to participate in summer sessions and to provide specialized faculty.

The course is based on the assumption that all students are in the hospital field and well aware of its need. However, the curriculum will require over 700 hours of work by the student. The first winter session will commence in the fall of 1951 and the program, which is to be integrated over a two-year period, will include two winter sessions of extra-mural activity and two summer sessions of resident university training. There will be a direct relationship between the winter assignments and the schedule of studies outlined for the summer session. The committee recommends that prospective students consider carefully the minimum time required for study. A minimum of six hours per week for the 34-week winter sessions, plus concentrated effort during the 4-week summer sessions, is essential to successful completion of the course.

*Recognition.*

Candidates who satisfactorily complete all of the assignments, attend two summer sessions, and pass the required examinations, will be granted a certificate by the Canadian Hospital Council. This certificate, which will be granted only for proven attainment and not for past experience, will be a useful yardstick for the hospital field.

The course is designed for those individuals holding a responsible position in a hospital or closely-related field. However, due to limited facilities and a very heavy demand, the 1951 enrolment may have to give preference to people actually engaged in hospital administrative positions. Men and women will be considered on an equitable basis and, in selecting, experience, aptitude and interest will be weighed before academic attainment.

*Fees*

A $10 deposit must accompany all applications. This will be applied against the tuition if the applicant is accepted; otherwise, it will be returned. The annual tuition fee is $75 and will be payable in advance.

Although there was preliminary discussion of curriculum content and a number of practical and valuable suggestions put forward for consideration, the Committee on Education decided to leave this detail for the liaison committee to handle. This will be discussed in a subsequent issue of *The Canadian Hospital.*

*Application*

It is suggested that anyone contemplating enrolment in the course should endeavour to meet either the member of the Council's Committee on Education representing his area or an official of his provincial hospital association. (For members of the Committee on Education see *The Canadian Hospital,* September, 1950, page 30.)

All applications for the 1951 enrolment must be received on the prescribed form and in duplicate not later than August 8, 1951. These should be addressed to Secretary, Committee on Education, Canadian Hospital Council, 280 Bloor St., W., Toronto.

Application forms and brochures describing the course may be obtained by writing to the secretary of the Committee at the above address.

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### Canadian Dietetic Association Holds Successful Convention

The Canadian Dietetic Association held their sixteenth annual convention in Niagara Falls, Ont., from June 12th to 14th. It was one of the largest conventions in the association's history with a total attendance of 369, including 194 members, 85 guests, 65 exhibitors, and 25 dietetic interns.

Members of the executive elected at the convention are as follows:

**Board of Directors, 1951-1952**

*Hon. President:* Ethel Pipes, Vancouver, B.C.

*Hon. Vice-President:* Dorothy McNaughton, Toronto, Ont.

*President:* Edith M. Wark, Toronto.

*Vice-President:* Jean King, Toronto.

*President-Elect:* Isabel MacArthur, Winnipeg, Man.

*Secretary:* Margaret McKellar, Toronto.

*Treasurer:* Dorothy J. Tyers, Toronto.

*Past President:* Margaret Clark, Ottawa.

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### Montreal Conference Elects New Officers

The Conférence de Montréal de l'Association Catholique des Hôpitaux recently elected their new officers for the coming year. They are as follows:

*President:* Mère Anne-Marie, Hôpital Notre-Dame de l'Espérance, Saint-Laurent.

*Vice-Presidents:* Mère Allard, Hôtel-Dieu de Montréal; Soeur Sainte-Rose, l'Ecole d'Infirmières, Montréal.

*Secretary:* Soeur Madelaine Durand, Montréal.

*Members of the Administrative Council:* Soeur Sainte-Edith, Montréal; Soeur Couture, Saint-Hyacinthe; Soeur Anne-Cécile, Valleyfield; Soeur Irène de Portugal, Joliette; Soeur Saint-Eugène, Hôtel-Dieu, Sherbrooke; and Soeur Annette Rose, Saint-Jean d'Iberville.

# Resolutions

## *Adopted at Ottawa by the* Canadian Hospital Council

**Appreciation**

WHEREAS the Prime Minister, the Honourable Louis St. Laurent, and the Minister of National Health and Welfare, the Honourable Paul Martin, accorded the delegates such a hearty and courteous welcome; and

WHEREAS we all enjoyed the visit to and reception at the House of Parliament;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincere thanks and appreciation to the Prime Minister and the Minister of National Health and Welfare.

**Sun Life Assurance Company of Canada**

WHEREAS the Sun Life Assurance Company of Canada has made very generous contributions to the support of the Canadian Hospital Council in the past and at the present time; and

WHEREAS this assistance has been of the utmost importance in the development of the services for the Canadian hospital field and in turn for each individual patient who needs hospital care;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council repeat its sincere thanks to the Sun Life Assurance Company of Canada for its valuable support.

**W. K. Kellogg Foundation**

WHEREAS the need of further programs and facilities for the training of hospital administrators and other hospital personnel was apparent; and

WHEREAS the W. K. Kellogg Foundation is devoted to "the promotion of the health, education and welfare of mankind"; and

WHEREAS the W. K. Kellogg Foundation has seen fit to make a very substantial grant to the Canadian Hospital Council for the purpose of developing an extension in-service training program for hospital personnel;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincerest appreciation and thanks to the Board of Directors of the W. K. Kellogg Foundation for the invaluable assistance given to the Canadian Hospital Council in the development of training facilities and programs for hospital personnel.

**200th Anniversary of Pennsylvania Hospital**

WHEREAS the Pennsylvania Hospital in Philadelphia, Pennsylvania, has reached its 200th milestone in the care of the sick and injured; and

WHEREAS the members of the Canadian Hospital Council are aware of the unusual and significant contribution of this institution in the service of mankind;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council extend its congratulations to the Pennsylvania Hospital and the best wishes from all of its members for another such distinguished period of service.

**American Representation**

WHEREAS the representatives from the American College of Surgeons, the American College of Hospital Administrators and the American Hospital Association in attendance at this meeting have added materially to its success;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincere apppreciation to the above organizations for having provided such representation at its Biennial Meeting and to the individual representatives for their valuable contributions to the program.

**Hospitality**

(a) WHEREAS the local hospital authorities and the Association of Doctors' Wives of Ottawa have devoted a great deal of time and effort toward making the visit to Ottawa a most enjoyable one;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincere appreciation for the kind hospitality and fine arrangements made for the Biennial Meeting;

(b) WHEREAS the Sisters of the Order of Grey Nuns of the Cross at the Ottawa General Hospital provided accommodation for the sisters attending the meeting, and made the visit to Ottawa a very enjoyable one;

THEREFORE BE IT RESOLVED that the sisters in attendance at the Council meeting express their sincere appreciation for the kind hospitality of the Sisters of the Grey Nuns of the Cross at the Ottawa General Hospital.

**Chateau Laurier**

WHEREAS our hosts, the management and staff of the Chateau Laurier, have made every effort to provide service to the delegates assembled at this Biennial Meeting of the Canadian Hospital Council; and

WHEREAS the delegates have enjoyed the hospitality of this fine hotel for the past several days;

THEREFORE BE IT RESOLVED that a letter of appreciation be sent to the management of the Chateau Laurier.

**MacLaren Advertising Company**

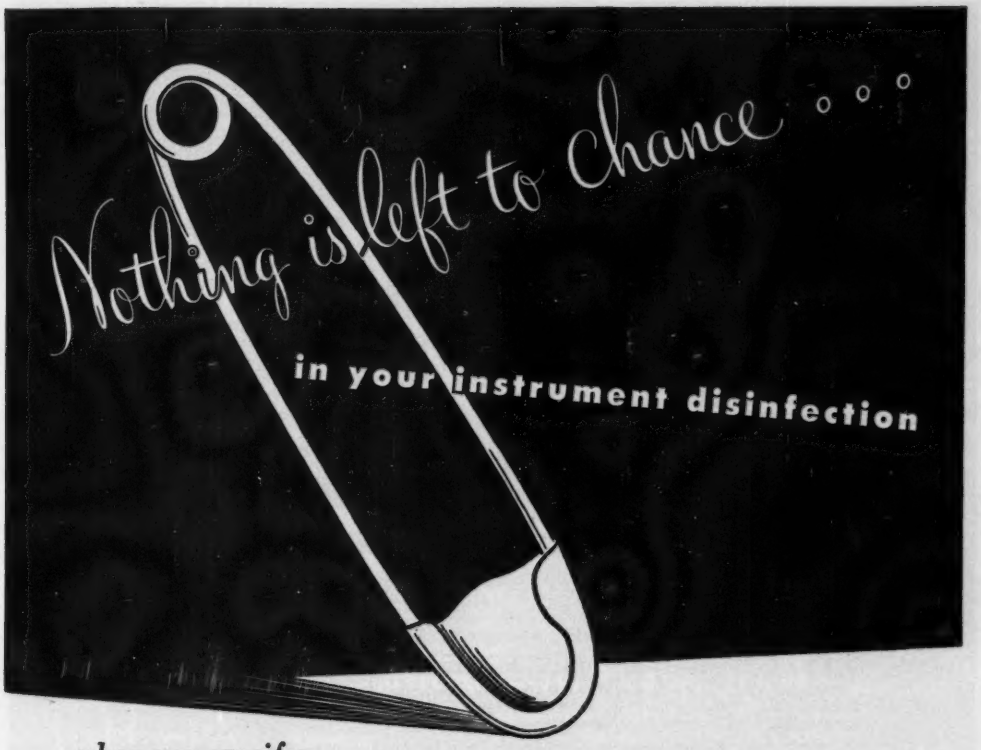
WHEREAS the MacLaren Advertising Company has again lent valuable assistance to the Canadian Hospital Council in the matter of publicity and public relations; and

WHEREAS the MacLaren Advertising Company has sent a representative to this Biennial Meeting to manage publicity and press relations;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincere appreciation for the services of the MacLaren Advertising Company.

**Hospital Standardization Program**

WHEREAS the continuation of the




*when you specify*

## BARD-PARKER FORMALDEHYDE GERMICIDE

**containing HEXACHLOROPHENE (G-11*)**

• • • because it has established a new standard of potency for solutions used in the chemical disinfection of surgical instruments. It will destroy vegetative pathogens and spore formers within 5 minutes, and the spores themselves within 3 hours—as shown in the comparative chart. In addition, it is "economically usable" as prolonged immersion of delicate steel instruments will not result in rust or corrosive damage to keen cutting edges. The Solution will retain its high disinfecting potency over long periods of use if kept undiluted and free of foreign matter.

*Trademark of Sindar Corp.

**PARKER, WHITE & HEYL, INC.** • Danbury, Connecticut

For practical purposes we suggest the selection of B-P CONTAINERS — all scientifically designed for use with the Solution.

*Compare this significant data evaluating the potency of the IMPROVED germicide*

| SPORULATING BACTERIA | 50% BOVINE BLOOD | WITHOUT BLOOD |
|---|---|---|
| Cl. tetani | 3 hours | 3 hours |
| Cl. welchii | 2 hours | 2 hours |
| B. anthracis | 1½ hours | 1½ hours |
| VEGETATIVE BACTERIA | | |
| Staph. aureus | 5 min. | 15 sec. |
| E. coli | 3 min. | 15 sec. |
| Strept. hemolyticus | 2 min. | 15 sec. |

*Ask your dealer*

## 1951 Class in Hospital Administration at U. of T.

Having completed the nine months' period of academic work at the University of Toronto, the fourth class of the graduate course in hospital administration have secured administrative residencies for the second year of training.

Top row, left to right: J. MacKay, who goes to the Toronto East General and Orthopaedic Hospital, Toronto; Harvey Radey, Jr., to the Paterson General Hospital, Paterson, N.J.; William Nichol, Vancouver General Hospital; Michael Fraser, Royal Jubilee Hospital, Victoria, B.C.

Second row: Philip Heaps, Toronto Western Hospital; Harold Dillon, Victoria Hospital, London, Ont.; Ernest Shortliffe, M.D., University of Alberta Hospital, Edmonton; J. Doney, Jr., Jackson Memorial Hospital, Miami, Florida.

Front row: Werner Daeschel, Kingston General Hospital, Kingston, Ont.; Edwin Nabert, Kitchener-Waterloo Hospital, Kitchener, Ont.; Harvey Agnew, M.D., F.C.H.A., Professor of Hospital Administration; Miss Eugenie Stuart, M.S.H.A., Assistant Professor; L. O. Bradley, M.D., Associate Professor; and Hugh Ross, who goes to St. Catharines General Hospital, St. Catharines, Ont.

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Hospital Standardization Program of the American College of Surgeons is under review; and

WHEREAS there has been prolonged discussion and negotiation between the various American medical and hospital organizations with a view to establishing a new sponsorship; and

WHEREAS there are certain recognized values in a good standardization program toward the development and maintenance of quality in hospital care;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council set up a study committee to examine the matter and make a full report to the Canadian Hospital Council on the most feasible and practical plan to develop an adequate hospital standardization program for Canadian hospitals.

**Construction Grants for Nurses' Residences**

WHEREAS the scope of the hospital construction grant has been extended by Order-in-Council to give financial aid to the building of nurses' residences; and

WHEREAS this extension is a positive move towards the solution of the present nursing shortage;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the Minister of National Health and Welfare on this action to extend financial aid for the construction of nurses' residences.

**Unemployment Insurance Coverage**

WHEREAS the Unemployment Insurance Commission has signified its intention of extending coverage by regulation to certain categories of hospital employees; and

WHEREAS hospitals are non-profit, charitable institutions; and

WHEREAS any additional costs of operating hospitals would have to be passed on to the paying patient from whom the major portion of hospital revenue is obtained; and

WHEREAS increased hospital charges may prevent our citizens from seeking hospital care when it is badly needed;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council go on record as opposing, under the present system of hospital financing, the extension of unemployment insurance to employment in hospitals.

**National Health Program**

WHEREAS the Department of National Health and Welfare has estab-

*(Continued on page 84)*

# Sub-Sterilizing Room

## *Facilitates Aseptic Technique*

**at Kitchener-Waterloo Hospital**

THE traditional plan for a sub-sterilizing room between operating rooms has, for many generations, gone on without change, with the sterilizers and sinks occupying one section which was usually divided by a wall from a second section where the surgeons scrubbed. In most cases no direct passage was made between the corridor and the sterilizing room. Hence all traffic to this room, whether authorized or not, had to be through an operating room. Since it has long been demonstrated that the bacteria count in an operating room increases in proportion to the number of people who enter it, it is logical that an early consideration was the elimination of this traffic. This led to the introduction of the passageway through the scrub-up room to the sterilizing room.

In the new Kitchener-Waterloo Hospital, Kitchener, Ont., a further step was taken in transposing the scrub-up sinks from the corridor side of the room to the outer wall. There were several reasons for this. For one, the surgeon now makes only one visit to the scrub-up sink; he completes his scrubbing and moves immediately into the operating room. While he is scrubbing, he can observe through transparent walls the progress being made with his patient on the operating table.

Another fundamental reason lies in the belief that surgeons are, on the whole, unacquainted with sterilizing practices. In this new type of utility room, the surgeon, proceeding through the sterilizing room to the scrub-up sinks, can become acquainted with the preparation of the instruments and gain a new interest in this detail of his work.

Meanwhile, on the corridor side of the room, the operating room personnel are able to go about their duties without disturbing others.

### Equipment

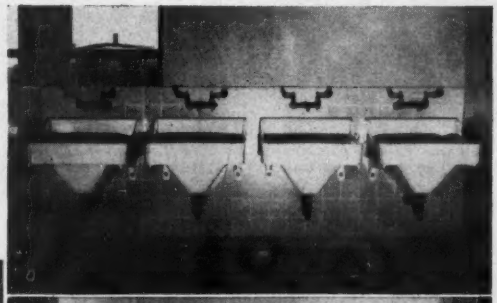
With service completely centralized, such items as dressings, utensils, and flasked distilled water are supplied directly from central sterile supply. Thus, in the sub-sterilizing room, only six pieces of equipment have been installed: a thermostatically-controlled, insulated solution and blanket warmer; a high-speed emergency instrument sterilizer; an instrument washer-sterilizer; two sinks, one of them a flush rim sink; and a mop closet.

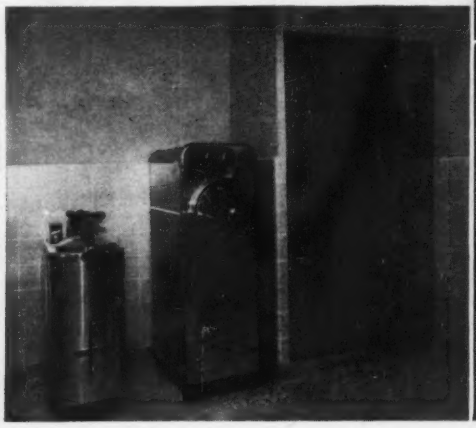
Water sterilizers have been completely eliminated in the sub-sterilizing room and, in their place, is

*In the "K-W", the scrub-up sinks were transposed from the corridor side of the room to the outer wall (upper right).*

*On the opposite end of the room are (left to right) the high-speed emergency instrument sterilizer, the instrument washer sterilizer, and the insulated solution and blanket warmer (lower left).*

*The flush rim sink and a handy mop (mop closet door at extreme left) facilitate waste disposal and thorough cleaning (lower right).*





a solution and blanket warmer controlled by an adjustable thermostat. An upper compartment holds three pair of blankets and the lower one accommodates 40 gallons of sterile, distilled, vacuum-packed, pyregen-free water in Fenwal flasks, brought directly from central supply. An audible water hammer is used to determine whether each flask is sterile.

With respect to the heat factor in the room, manufacturers of high pressure sterilizing equipment have taken definite action and produced equipment thoroughly insulated and completely encased in stainless steel finishing jackets. This type of equipment, now installed in the sub-sterilizing rooms of the new Kitchener-Waterloo Hospital, not only reduces the radiant heat to a very marked degree but also can be cleansed thoroughly and easily on all exposed parts.

The high speed emergency instrument sterilizer operates at 27 pounds pressure, 270 degrees F. The steam pressure is introduced to the jacket at the beginning of the working day and from this point on the cycle of operation is fast and safe. The chamber pressure rises rapidly until, in an average of one minute, a temperature of 270 degrees F. is attained and indicated on the "sterogage" thermometer located in the discharge line at the bottom of the sterilizing chamber. Spores of the most resistant organisms are destroyed in a sterilizing period of three minutes. The chamber is vented within ten to twelve seconds and the instruments are immediately available for use in the operating rooms.

Thus, the high speed sterilizer enables the nurse to return instruments to the operating table, with no compromise of aseptic technique, within a total period of less than four minutes. Because of the rapid action and high temperature, spotting and corrosion are completely eliminated.

The principle employed in the instrument washer-sterilizer is most efficient because it is practical, safe and economical, tolerating no break in the aseptic technique. Briefly, it dispenses entirely with scrubbing instruments and with the traditional boiling or non-pressure type of instrument sterilizer. It is unique in that it performs in one single operation every step concerned with washing and sterilizing, as well as disposing of waste matter, such as blood, pus and feces, without handling other than to load and unload the sterilizer.

The operation is simple. The dirty instruments are collected in a monel metal container directly from the instrument table. The container is placed in the sterilizer over a baffle plate which forces water to circulate through perforations in the bottom of the container. A steam coil, located beneath the baffle, supplies adequate heat for rapid sterilization and sets up convection currents in the water which, with a scouring motion, remove all oil and grease from the instruments and direct them towards an overflow at the top of the sterilizer. The continual rise in the water level, due to the expansion of the heating water, carries the oils and scum formed by blood and pus over a knife edge overflow. The addition of a detergent, to peptonize the proteins and saponify and peptize the greases, removes all the dirt, eliminating the necessity for mechanical cleansing of the instruments. The use of sodium metaphosphate in the detergent softens the water and prevents the precipitation of a film of alkaline earth soaps and salts on the instruments. The temperature of the water is raised to 273 degrees F. in 7 minutes, a signal light indicating when the steam supply is to be shut off. The super-heated water is rapidly drained into a flash tank, exposing the instruments to saturated steam for approximately one minute while the pressure is being relieved. The residual heat in the instruments is sufficient to flash any adherent moisture and the clean, dry, sterile instruments are ready for immediate use upon removal from the sterilizer.

Not only does the washer-sterilizer enforce a rigid, inflexible, aseptic technique but it has also proved a great time and labour saver.

Another unique feature of the washer-sterilizer is that it may be used as a high speed emergency sterilizer in the event that the latter is in use for the other operating room. Completely omitting the washing cycle, the chamber may be partially filled with cold water and the control handle moved to the "sterilize" position. With this added feature, even if emergencies arise in both operating rooms simultaneously, the demands can be met with the complete assurance that no compromise is being made.

The presence of the flush rim sink in the sub-sterilizing room makes possible the disposal of waste without transporting it through corridors. Everything except that material which is destined for the incinerator will be disposed of immediately and with the least possible chance for contamination.

Not the least important feature of this room is the mop closet. Traditionally consigned to some remote, dark closet, often only partially cleaned or neglected entirely, the mop might very well transplant harmful organisms to the operating room. However, with the mop located in the sub-sterilizing room and subject to the constant scrutiny of surgeons and personnel, no one would ignore the details of cleaning. Moreover, the cleaning of the mop is greatly facilitated with the flush rim sink.

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**Successful Extension Course Held for Medical Record Librarians**

A successful extension course for Medical Record Librarians was held at St. Michael's Hospital, Toronto, from May 14-18th. Proceedings were opened by Sister Mary Paul, directress of the St. Michael's School for Medical Record Librarians, who introduced her assistant, Sister Celine of St. Joseph's Hospital, Peterborough, Ont., to the 35 students present from various Canadian hospitals.

Instruction in medical terminology and *Standard Nomenclature of Diseases and Operations* was directed by Sister Mary Paul.

A history of the profession, details of medical records, and the more difficult problems of ethics and jurisprudence were dealt with by Sister Celine. Marie Restivo, R.R.L., outlined the procedures for completion of operating room records and demonstrated dictating equipment. The final address was given by Dr. J. J. Geoghegan who stressed the confidential nature of records.

# HOT or COLD

## ...seafood will save you money!

CANADIAN fish and shellfish can be obtained from your suppliers in many different forms, especially the fast-frozen varieties in which is retained their tempting, original flavour. Fresh, and canned fish too, provide tasty dishes that give new zest to the everlasting problem of meals.

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1-7-51

# Food and Its Service

**Sponsored by The Canadian Dietetic Association**

## Dietary Consultative Service

WHATEVER the size of a hospital, whether 15, 50 or 500 beds, there is one service which must always be there—the dietary department. It is a constant. All other services may vary depending upon the size and type of the hospital, but food must always be provided. Common to all hospitals is the need for providing nutritionally adequate, tasty and attractive meals. The need for good food in the small nursing home, which is devoted mainly to confinements, is as great as in the large city hospital which cares for the most difficult medical and surgical cases. The variable is the trained dietitian's presence or absence. It must be recognized that small hospitals and nursing homes cannot afford a trained dietitian, much less could they procure one even if money were available.

In Saskatchewan, because of the widely scattered population, a large number of very small hospitals and nursing homes have been established. Serving the predominately rural population of 867,000 persons, there are 163 hospitals. Only 10 of these have more than 100 beds. Of even greater significance is the fact that 65 hospitals are included in the group having 10 to 24 beds. There are 40 which have less than 10 beds as their rated capacity. In addition, there are 16 nursing homes all with less than 10 beds. These too are eligible for payment under the Saskatchewan Hospital Services Plan.

### Travelling Consultant

It is obvious that it would be impossible for these institutions to provide a high standard of dietary therapy if left to solve their own problems without trained personnel. The only probable solution appeared to be that of a consultative dietary service, with the result that Nutrition Division of the Department of Public Health added to its staff, a travelling dietitian.

A precedent had been established in Saskatchewan from 1928 to 1931. At this time, the Department of Public Health engaged a dietitian whose work took her to various hospitals. It would seem that, at that time, the effort was directed largely toward giving lectures in dietetics in training schools for nurses. Since that is now taken care of by full-time dietitians in all of the training schools, it was felt that the aim of the new service might better be directed toward improving the quality of food and efficiency of food service in hospitals. Thus the services of a highly qualified hospital dietitian were sought and made available to all hospitals in the province, on a consultative basis.

This service was inaugurated in September, 1949. The problems faced and the results achieved since that date make an interesting story.

One of the principal difficulties encountered in rendering this service is the tremendous expanse of area to cover. Then, too, climatic conditions make visiting difficult. Visits to the widely scattered hospitals through snow in winter, and mud in spring and fall, have not been made without the expenditure of much energy and patience. In summer travel by car has made it possible to visit a relatively greater number of hospitals than has been possible in winter, when train and bus schedules are less convenient.

While there is a lack of qualified people to assume direction of the food departments in many of the hospitals, the problem does not end there. Hospital cooks are drawn from practically every walk of life—a farmer who has had cooking experience in his days of bachelorhood, a former lunch counter operator, and the woman who has developed the skill by instinct of preparing "good, plain, wholesome" food for a hearty family. It does not necessarily follow that the skills required for the preparation of food for fifty persons are the same as those required for feeding five.

So the situation remains that for the most part the matron or supervising nurse is responsible for directing the food department. Unfortunately, this is just one of the many departments in the hospital that claim her attention. Very often it is the one which receives the smallest portion of her time, because there are few "crises" in this department.

### Problems Encountered

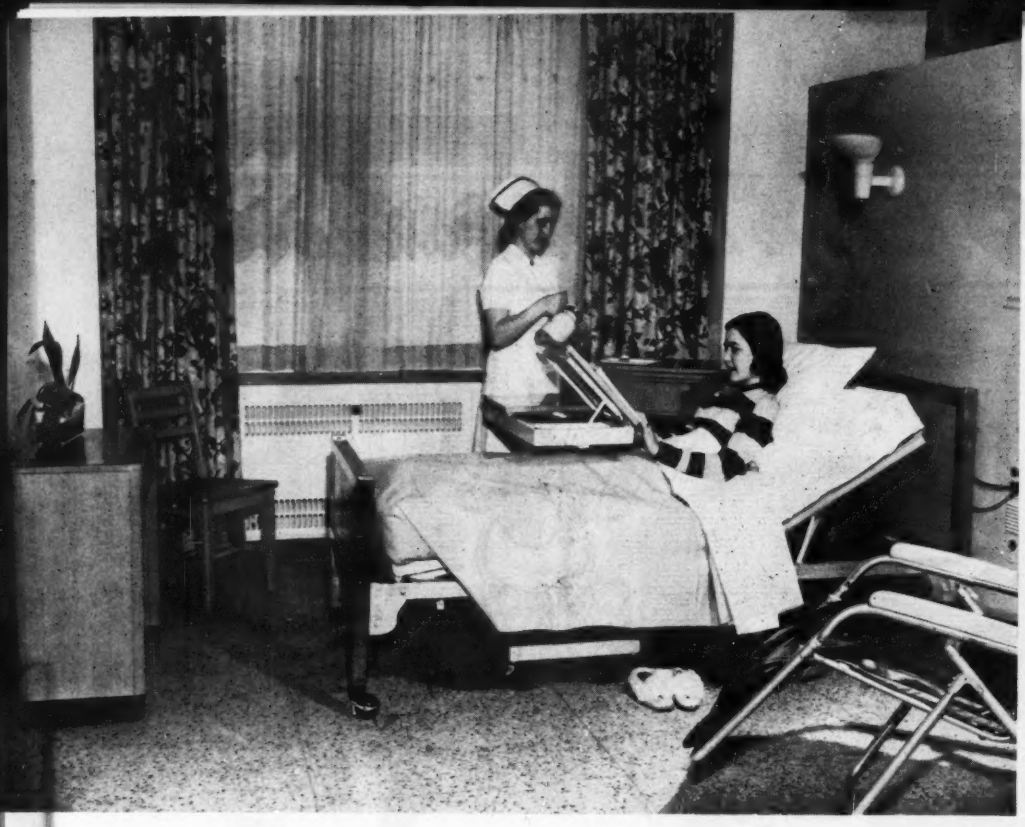
Few hospitals in the smaller size group had a detailed plan of food cost accounting. Thus if food costs were excessive, it was difficult to determine the offending factor. Purchasing was done in small quantities in many cases with little effort made to do bulk purchasing of staple items. There was a definite tendency to purchase most foods at a retail level with attendant high costs.

This pattern of daily food purchase apparently had its root in a lack of adequate menu planning. In many instances meal planning was a day to day effort—often meal to meal. Therapeutic diets were a bugbear to many small hospitals, neither the nurse in charge nor the physician having time to give the cook clear and detailed directions concerning the requirements.

In all too many instances poor methods of cooking were employed. Vegetables were overcooked and improper temperatures used for meat. A common error, too, was the un-

*(Continued on page 90)*

*Contributed by the staff members, Department of Public Health, Regina, Sask.*



# *Congratulations*

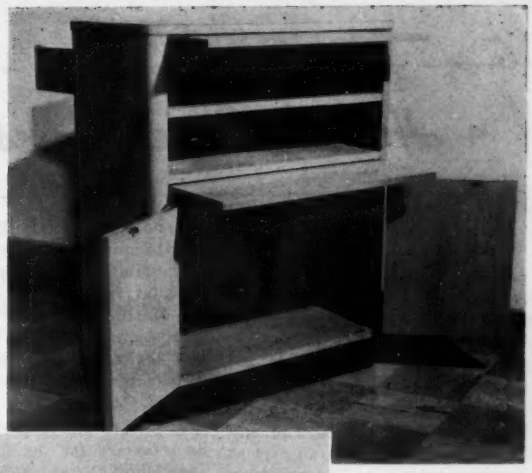
to the Board of Governors of the

**KITCHENER-WATERLOO HOSPITAL**

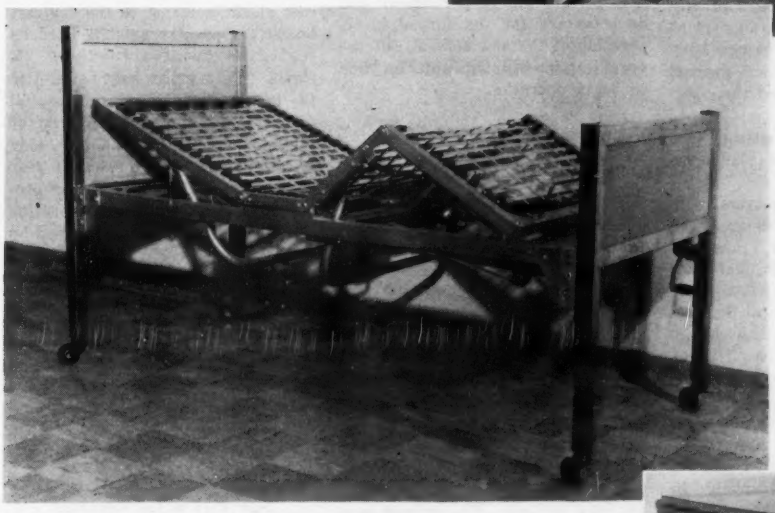
Kitchener, Ontario

● All color schemes in Ward areas as well as Ward Furniture were designed by Simpson's Special Contract Division. The furniture includes the new electrically-operated Hi-Lo Beds, used here for the first time and exclusive with Simpson's.

Small neat writing desk supplies surface for flower arrangements ... in combination with new bedside table is less expensive than standard bedside table and dresser.



Bedside table is built narrow and longer for more accessible top surface, has adequate space for extra blanket and pillow, eliminating need for large dresser.



Ease of operation is a big factor in the new Hi-Lo beds which may be adjusted by a three-position switch on right side of spring. The electrically-operated bed stops at high or low automatically, may be adjusted to any position in between. Low position is domestic height, allows patient easy access to and from bed.

Simpson's

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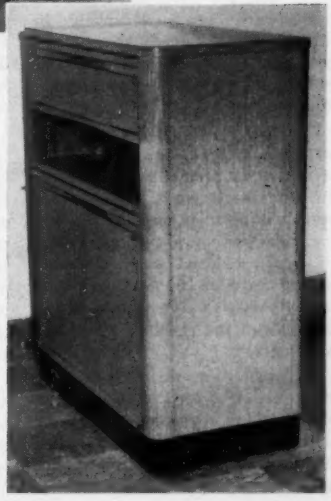

Simpson's bedside table, No. SCD120, is a compact unit, 15" x 30" x 36", mounted on recessed castors for easy movement.

# Health Care Plans

### C.M.A. Plans
### Trans-Canada Medical Service

At the Canadian Medical Association meeting, which was held in Montreal from June 18-22, Canadian doctors completed plans for nation-wide prepaid medical care insurance to be sponsored by the association. The plan, known as the Trans-Canada Medical Services, integrates provincial medical health insurance plans already in existence. The new body will not supplant regional medical care plans but will extend their service in three ways:

1. Contracts with one plan may be transferred to any other plan operating in Canada.

2. Large national employers, with employees in several provinces, can insure them through the Trans-Canada Plan under the individual plans in each province.

3. Trans-Canada Medical Services will act as a clearing-house for information, administrative counsel, and statistics for the provincial plans.

Dr. Norman Gosse, president of the Canadian Medical Association, stated that the Association believes medical-care insurance should be available to all Canadians with the state paying the premium in whole or in part, for those who can not afford to pay.

Eventually it is hoped that all the participating provincial plans will have uniform premiums and benefits but, for the present time, no attempt will be made to bring them in line. At present a contract holder for one provincial plan, receiving medical care in another province, would be eligible for services available only in the province where the care is given.

The seven co-operating plans, covering about 1,300,000 Canadians, are: Medical Services Association, British Columbia; Medical Services Incorporated, Alberta; Group Medical Services, Regina, Sask.; Medical Services Incorporated, Saskatoon, Sask; Manitoba Medical Services; Physicians' Services Incorporated, Ontario; and Maritime Medical Care, Nova Scotia. Two plans sponsored by hospital associations, the Quebec Hospital Services Association and the Maritime Hospital Service Association, which provide hospital care and limited medical coverage, are expected to join the national group shortly.

A private bill in parliament will be necessary for the formal incorporation of the new service, but the organization will not wait for this to begin operation.

* * * *

### Recent Amendments to the Alberta Hospital's Act

Recent amendments in the legislation governing Alberta's dollar-a-day hospitalization plan, which formerly was available only to ratepayers, has been changed to include all resident non-ratepayers who have entered into a subsisting contract with a municipal hospital district or a local authority. The non-ratepayer is charged a standard fee for the contract and, then, is able to obtain standard ward hospitalization at a direct cost to him of one dollar per day or less. The spouse and dependent family of a contract holder are included under the terms of the contract.

Local authorities are encouraged to sell their contracts at a much lower rate by the amendments to the Hospitals' Act, which makes it possible for the government to assist municipalities and municipal hospital districts by contributing to the cost of hospitalization of non-ratepayers who have purchased a voluntary contract. The amendments in Bill No. 42, are as follows:

3b. (2). The hospitalization grant may be paid on a *per diem* basis for each day of hospitalization received by a contract holder in a hospital operated by the municipal hospital district or in a hospital with which the municipal hospital district board or the local authority has made an agreement, as the case may be, if,—

(a) the cost of the contract to the contract holder does not exceed such amount as may be fixed from time to time by regulations;

(b) the contract holder is resident within the boundaries of the municipal hospital district or local authority with which he has entered into the contract;

(c) the municipal hospital district or local authority providing the contract plan for hospitalization authorizes the purchase of contracts by non-ratepayers during the months of January or July of each year, benefits becoming available immediately upon purchase of the contract.

3b. (5). In any case where the cost of the contract to the contract holder exceeds the amount fixed by regulation under subsection (2), clause (a), a grant may be paid to the board of the municipal hospital district or to the local authority of the municipality, as the case may be, at the end of each calendar year equivalent to the total cost of providing standard ward hospitalization to contract holders as determined by the group basic ward rate of the hospital concerned after deducting therefrom,—

(a) the revenue resulting from the dollar per day payable by the patients; and

(b) the revenue from the sale of contracts.

* * * *

### Blue Cross - Blue Shield Offers New Plan in the Maritimes

The Maritime Blue Cross - Blue Shield Plan is now offering, for the first time, a non-payroll group membership and a non-group membership. Members of the non-payroll group must belong to a group sponsored by a recognized organization and must not work where five or more are employed, which would make them eligible for membership through a firm payroll group.

In the past years, Blue Cross - Blue Shield services were available to residents of the Maritime provinces on a group basis only. Now the Plan is making individual or non-group membership available, at definite periods of the year, to every resident of the Maritimes who is under 65 years of age, in good health, and who is not employed where there are five or more on the

*(Concluded on page 102)*

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**RELATIVELY NONTOXIC**—there is only 0.5 Gm. dihydrostreptomycin for each 400,000 units of penicillin.
The comparatively small amount of dihydrostreptomycin reduces the risk of toxic reactions without sacrificing effectiveness.

*Recommended for:*

- Prophylaxis of wounds to avoid contamination
- Treatment of peritonitis
- Chronic mixed infections of the respiratory or urogenital tract
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Vials containing 400,000 units of Crysticillin with Soluble Penicillin and 0.5 Gm. dihydrostreptomycin sulfate

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# With the Auxiliaries

## National Council of Hospital Auxiliaries Formed at C.H.C. Biennial Meeting

Executive members of five provincial women's hospital auxiliaries associations met during the biennial meeting of the Canadian Hospital Council, which was held in Ottawa from May 28-30, to form a Canadian National Council of Hospital Auxiliaries. The Alberta Provincial Association of Hospital Aids signified its wish to be included in the membership by telegram and, with the exception of Newfoundland, all provincial auxiliaries associations are represented on the newly formed Council. It is expected that the Newfoundland auxiliaries will join in the near future.

Although not represented at the Ottawa meeting, the Maritime Hospital Aids Association has since signified its intention of joining the national body.

At the first meeting, held on Monday evening May 28th to form the nucleus of the National Council, Mrs. O. Rhynas of Toronto, was named chairman of the original committee and was later elected president. She explained to representatives that the national body was to serve as a clearing house and guide for all provincial auxiliaries and that its objective was the eventual representation of all provinces. Reports of proceedings at the first meeting are to be sent to all provincial associations. It was decided that each province, at its annual convention, would choose two members to sit on the advisory board. A fund was created by personal contributions from each member present for the current requirements of the Council.

The newly formed organization met on May 29th with Judge J. M. George of Morden, Man., presiding. Judge George congratulated the women on the formation of the National Council and expressed the hope that it would grow and thrive. He suggested that to unify the workings of the organization it would be wise to use the word "Assembly" in place of Advisory Executive. He

*(Concluded on page 102)*

*Executive members of the newly formed Canadian National Council of Hospital Auxiliaries pose on the steps of the Parliament buildings in Ottawa.*

*Front row, left to right: Mrs. T. J. Lytle, Toronto; Mrs. J. M. George, Morden, Man.; Mrs. Forbes Perkins, Vancouver; Mrs. W. P. Fillmore, Winnipeg.*

*Back row, left to right: Mrs. F. C. McDougall, Montreal; Mrs. H. W. Davis, Kingston, Ont.; Mrs. O. W. Rhynas, Toronto; Mrs. W. B. Frost, Melfort, Sask.; Miss Christina Macleod, Winnipeg.*

* * * *

## Maritime Auxiliaries Hold Annual Convention

The annual convention of the Maritime Hospital Aids Association was held in conjunction with the Maritime Hospital Association's annual meeting, at St. Andrew's, N.B., from June 5-7. Large numbers of enthusiastic delegates and guests from all parts of the Maritimes were in attendance.

Auxiliary representatives were present for the official opening of the Maritime Hospital Association and then adjourned to hear addresses by their president, Mrs. J. S. Ross, of Truro, N.S., and Dr. J. A. McMillan, chairman of the Maritime Hospital Service Association. Reports from the various member auxiliaries were presented and this was followed by a round table discussion on "The Part Our Auxiliaries Play in Good Public Relations", lead by Mrs. A. M. Hunter of Halifax. The session closed with a discussion on "Why First Aid?", opened by Gladys Porter, secretary-treasurer of the Maritime Hospital Association. At the conclusion of their meeting, members were guests of the M.H.A. at their annual buffet supper.

A decision was made following the meeting that the Maritime Hospital Aids Association would join the newly formed National Council of Hospital Auxiliaries. Mrs. James Ross, Truro, N.S., and Mrs. Ernest Haggerman, Saint John, N.B., were elected as the association's representatives on the national body.

**Officers**

*President:* Mrs. J. S. Ross, Truro, N.S.

*1st Vice-President:* Mrs. B. L. Noran, Chatham, N.B.

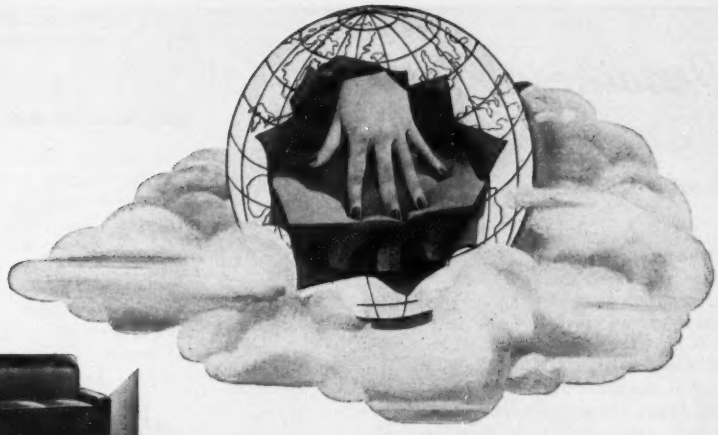
*2nd Vice-President:* Mrs. A. H. Hunter, Halifax, N.S.

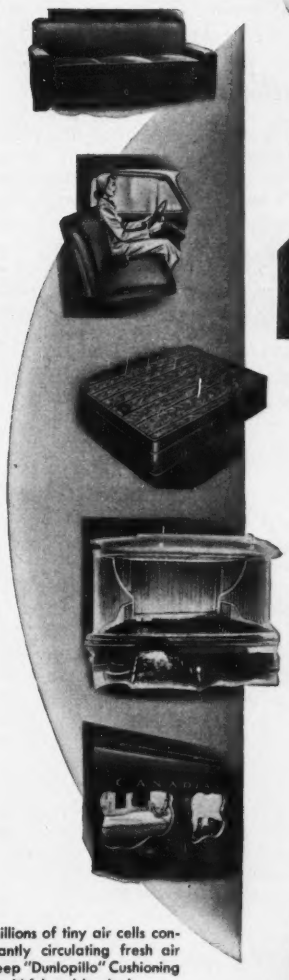
*3rd Vice-President:* Mrs. J. J. Duffy, Charlottetown, P.E.I.

*4th Vice-President:* Mrs. P. J. Connolly, Sydney, N.S.

*Secretary:* Mrs. G. T. Purdy, Truro, N.S.

*Treasurer:* Mrs. H. A. MacQuarrie, Westville, N.S.





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# Provincial Notes

## Newfoundland

CORNERBROOK. The minister of health for Newfoundland, the Hon. J. R. Chalker, has announced that a non-recurring grant of $150,000 has been authorized by the provincial government to meet the operating deficit of the Western Memorial Hospital. In addition, the grant will assist in financing future operations for a short period. Approval has also been given to provide $100,000 in draft estimates, for 1951-52, to cover the cost of converting, extending, and equipping the old Cornerbrook Hospital for use as a nurses' residence. In this way, the quarters now being used by the nurses and other staff members will be released for patient accommodation.

## Quebec

LACHINE. The Lachine General Hospital has been awarded a grant of $200,000 from the provincial government for the construction of a new building which is now being erected. The two-storey structure will have a penthouse and is so designed that two more storeys, as well as additional wings, may be added without acquiring more land. Administrative offices and service rooms, as well as operating rooms and x-ray department, are located on the first floor. The second floor is devoted entirely to patient accommodation and includes three private rooms, seven semi-private, and 38 general ward beds. Laboratory facilities and the basil metabolism room will be located in the penthouse. The total cost of the new building is estimated at $600,000.

## Ontario

FORT FRANCES. Work has commenced on the $544,870 addition to the LaVerendrye Hospital. When the extension is completed the additional bed space will bring the hospital's capacity to 100 adult beds and 25 bassinets.

* * * *

LONDON. Dr. McKinnon Phillips, minister of health for Ontario, officially opened the new wing of the War Memorial Children's Hospital on May 12th. Built at an approximate cost of $485,000, the three-storey addition contains 63 beds. A large waiting room, five clinic rooms, admitting office, and quarters for three interns are located in the basement. Treatment rooms, as well as wards, are on the first, second, and third floors. The combination roof garden and sun deck on the top floor has proved to be very popular with the children. John M. Watt, of London, was the architect.

* * * *

ORILLIA. Many alterations and improvements are under way at the Ontario Hospital School. The auxiliary water supply from the town has been installed and the sewage disposal has been linked with the Orillia disposal plant. New dental x-ray equipment is now in use and the remodelling of the laundry is progressing. Wooden stairways and wooden trim, especially in the older buildings have been treated with fire-resistant paint. The average attendance at the Ontario Hospital School is 2,366 patients in residence and 85 in approved homes.

## Manitoba

MANITOU. At an official ceremony held in April, an 8-bed hospital was opened. The white stucco building has a waiting room, office, four 2-bed wards, kitchen, nursery, maternity department, and operating rooms on the upper floor. Quarters for the public health unit are located on the ground floor, as well as staff bedrooms, storerooms, laundry, and furnace. Floors throughout the building are covered with rubber and asphalt tile. Designed by Moody and Moore of Winnipeg, the hospital was built at an approximate cost of $67,000.

## Saskatchewan

SASKATOON. Plans are under way for the proposed construction of a new centre block to the Saskatoon City Hospital. The bed capacity would be increased by 75 beds, including 25 isolation beds, through this addition to and alterations in the present building. The estimated cost of the new project is $1,825,000. At present two storeys are being added to the nurses' residence.

## Alberta

BROOKS. Recently, an "Open House" was held at the Brooks Municipal Hospital and visitors were conducted on a tour through the newly completed operating, sterilizing, and case rooms. The three rooms have terrazzo floors and have been redecorated in green tiling. Another interesting feature for the guests was the new x-ray equipment. Effective as of May 1st, the hospital has now been reclassified from "D" to "C".

## British Columbia

VANCOUVER. The Vancouver General Hospital has adjusted its scale of financial eligibility for patients who desire free treatment or treatment at cost in the out-patient department and Health Centre for Children. Both branches of the hospital provide diagnostic and treatment service, with more than 100 specialists and doctors on the staff giving their services free. During 1950, 40,700 treatments were given in the out-patient department and more than 14,000 in the children's centre. Rates for financial eligibility now conform with the rising cost of living. Under the new rates, a husband, wife and one child, with a monthly income of $150 or less, will be eligible for free treatment. Formerly, this treatment was limited to those earning up to $110 a month. Eligible income under the new rates has been changed from $20 to $25 for each additional child, to a maximum of $250.

## Presidential Report

*(Continued from page 29)*

Within this large group there may be those who are interested in progressive influences and who might be ready to assist by an annual subscription. The ground has been explored, having in mind not more than 200 selected persons. Further consideration, and possible application, will be a responsibility of the new Board of Directors, provided that the policy of encouraging this new form of support is approved by the delegates at this conference.

### The George Findlay Stephens Memorial Award

As President of your Council it was my great privilege to present the first George Findlay Stephens Memorial award to Dr. A. K. Haywood of Vancouver and the second to an outstanding and beloved person, who has since been taken from us, the late Dr. Fred Routley.

At this conference, it will be my privilege to present—on behalf of the Council—the third George Findlay Stephens Memorial award. This time it goes to one who, behind the scenes, has worked quietly and conscientiously in the interest of the hospitals of Canada. Earlier this month I had the pleasure of announcing that Dr. A. Lorne Gilday would be the deserving recipient of this third award.

These men have each made outstanding contributions to the hospital field. With judgment based upon integrity, experience, and knowledge, they provided, abundantly, stimulus and inspiration to others in the field.

I feel that the work of the Council cannot be evaluated entirely upon the specific projects undertaken. The intangible values which accrue because of the character of the men who have been associated with Council work have far exceeded the more definite accomplishments. It was inevitable that their influence would temper public policies for the benefit of the many patients whom we, in the hospital field, try to serve.

### Hospital Standardization

There has been concern over the hospital standardization program. As you know, this important program has, for many years, been an activity of the American College of Surgeons. Changes in this responsibility are being considered and will be discussed at these sessions. Should, or should not, the Council be actively associated with the standardization program as applied to Canadian hospitals? It may be too big an undertaking for the Council to finance, but the incoming Board should be recognized as a party involved. A comprehensive study is desirable before opinions are formed.

### Federal Construction Grants

From many of our hospitals comes the request that supporting services, particularly nurse and intern residences, be recognized as a part of a hospital bed unit and, therefore, be eligible for construction grant assistance. The provision of beds, and ignoring the services that support these beds, is like building a second story of a building and overlooking the connecting stairs. I am certain that our government leaders recognize this and will take the necessary action when an informed citizen opinion will support such action. It is our responsibility to help them by developing the required public opinion.

### Unemployment Insurance

There has been pressure to bring hospital employees within the provisions of the Unemployment Insurance Act. From one end of Canada to the other there came protests from the hospitals against this. Council representatives attended a public hearing conducted by the Unemployment Insurance Commission, on behalf of the hospital field. Certain proposals which have been made will come before this conference for discussion and action.

The position taken by the Council representatives was that, while agreeing with the general principles of unemployment insurance, there were obvious reasons why an exception should be made in the instance of hospitals. It is the patient who—in the final analysis—has to meet these new expenses. The patient who is struggling to remain independent and to pay his way would be faced, not only with the cost of unemployment insurance for the employees who serve him, but also the cost of unemployment insurance for the employees who serve the patient who cannot pay. The application of this new burden to hospitals should be postponed until revenues to meet this cost can be obtained from sources other than the patient who is struggling to meet present charges.

### C.H.C. Extension Course

The graduate course in hospital administration at the University of Toronto and the course in the French language, conducted alternately in Montreal and Quebec, have been meeting an important need. But it has long been obvious that there is a place for an extension course to the end that capable hospital employees could, while working in the hospital, prepare themselves for administrative positions.

Twelve able men from different sections of Canada accepted appointment on an educational committee of the Canadian Hospital Council. Under the able chairmanship of our former general secretary and supported by the executive and administrative effort of our new secretary, the committee was able to enlist the interest of Mr. Graham Davis of the W. K. Kellogg Foundation. Full information will be provided to you at this conference, but in these remarks I wish, on behalf of the Council, to extend sincere thanks to the Directors of the W. K. Kellogg Foundation, to Mr. Graham Davis, to the University of Toronto, the Chairman and members of the Education Committee, and to our own able executive officials. A vision is becoming a reality.

### The Constitution

Another feature that received attention, during the past year, is the study of the constitution under which the Council operates. The result is that proposals for a new constitution will be placed before the delegates at this meeting.

It was realized that discussions over such an important feature as the constitution would take more time than could be allowed on this program. For that reason, it was decided to send, in advance, a draft copy to each delegate, hoping that the opportunity to make a preliminary study would expedite decisions.

In effect, there are but few essen-

*(Continued on page 68)*

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**ONE GRAM DIHYDROSTREPTOMYCIN SULFATE AND STREPTOMYCIN GALCIUM CHLORIDE COMPLEX**

**NOW AVAILABLE IN NEW SMALL VIALS —5 c.c. instead of 20 c.c.**

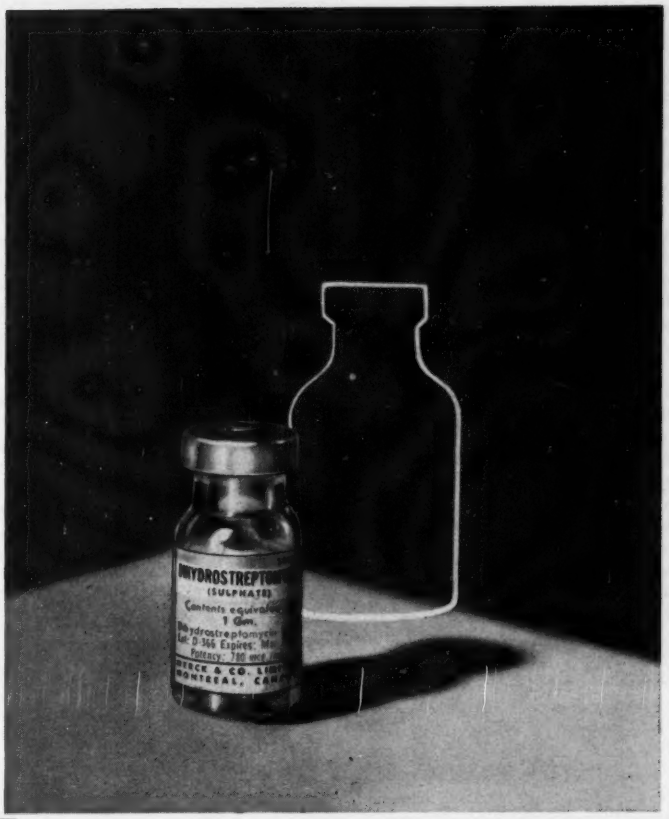

*Illustration shows actual size of 5 c.c. vial compared to 20 c.c. vial.*

## NEW DILUTION TABLE

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| Solvent added to 1 Gm. vial | Approximate concentration per c.c. |
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| 3.7 c.c. | 250 mg. |
| 2.0 c.c. | 400 mg. |
| 1.5 c.c. | 500 mg. |

### *Three Noteworthy Advantages*

1. Easier and more complete withdrawal of contents of vial.
2. Greater convenience to the physician as vials occupy less of the valuable space in his bag.
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## Presidential Report

*(Continued from page 66)*

tial changes and I will draw your attention to the main one. The chief effort has been directed toward making the procedures more specific and to clarify duties and responsibilities of all concerned.

A proposed change is that, in addition to the present 35 delegates—or alternates—as appointed by the member associations, there will be four delegates at large, appointed by the Board of Directors of the Council from those persons who in the opinion of your board members are making valuable contributions to the hospital field. This leaves the member associations with a strong majority of delegates, but provides an opportunity to engage the interest of other outstanding men or women who can bring additional strength to the Council. They would have the same, but no greater privilege, than at present held by the member delegates.

This is the main change suggested. The remainder of the proposals are made in the effort to improve the application of the principles of the present constitution. A change not proposed in the advance draft copy but worth considering is the enlargement of the Board. This would provide an opportunity for a broader representation.

Many problems have come before the executive of your Council during the past two years. Insofar as time allows these will be discussed in the course of our program. In passing, however, I feel that I must mention the matter of the Civil Defence Services.

The executive officials of the Council have been co-operating with government officials. I am certain that they will provide a balance which will be helpful.

There are two dangers that must be recognized. On the one side can there be too much complacency, and on the other an over-emotional attitude or even selfish motives. Our hospital leaders can provide carefully thought-out, practical, suggestions.

### Changes In Executive Staff

On the occasion of the 10th biennial meeting of the Council held in Quebec in 1949, it was pointed out that our then able secretary was carrying too big a load. This was neither fair to himself nor to the organization. His health could not long have borne the strain and had anything happened to him the Council work would have been greatly disrupted.

It was agreed that an assistant secretary should be appointed. The Council executive looked the field over from the Atlantic to the Pacific and this resulted in the appointment of Mr. Murray Ross as Assistant Secretary, to take effect on January 1st, 1950. Since that time he has proved that the choice was a wise one. He has already made himself well-known to all and his contribution has been a most capable one.

While the Council was searching for an assistant secretary, they were faced with another concern. For some time, Dr. Agnew had been turning aside very favourable proposals from other organizations, but having laboured for eighteen years to bring the Council to a state of maturity, he decided that the time had arrived when he could turn his particular skill and interest to the field of consultation. With great reluctance and regret, the Council executive had to consider his resignation. As you could expect, however, from the type of man that Dr. Agnew is, he was ready to do everything possible to be helpful. For a time, at a great personal sacrifice, he stayed on part-time and also agreed to accept the chairmanship of the Committee on Education. He has continued to extend advice and counsel and we are deeply appreciative of this assistance.

With Dr. Agnew's decision made, it was necessary for your executive to look for a successor. A well qualified man was required to maintain the high standard that Dr. Agnew had set. It was unanimously agreed that we should approach Dr. L. O. Bradley. Since his appointment to the Council staff on August 1st last, a great many ideas have been given progressive and effective consideration. If the development of the extension course in hospital administration had been the only accomplishment, he would have performed a major service. His attention, however, has been given to numerous progressive measures with each being handled competently and efficiently. It is a pleasure and privilege to work with him.

The development of the extension course called for another well-qualified executive. Again, the field was looked over and, again, we were fortunate. This time, the appointee was Donald MacIntyre. I refer you to page 27 of the May issue of the Journal which will acquaint you with the qualifications Mr. MacIntyre brings to his work. I will not repeat these in detail. I do wish to say, however, that the program whereby able employees in the hospital field can, while working, have the opportunity of preparing themselves for a broader responsibility, is a project that draws my strong approval. If many of our capable workers are to be retained they must see broader opportunities ahead.

Your President in these remarks has had no intention of trespassing on the reports to be submitted by our Executive Secretaries and Trea-

*(Concluded on page 70)*

## Jessie J. Turnbull

Jessie J. Turnbull, who served as the first and only woman president of the American College of Hospital Administrators, during 1948 - 49, died on her 72nd birthday in Monmouth, Illinois, following a prolonged illness. For 30 years, she was superintendent of Elizabeth Steel Magee Hospital, Pittsburgh, Penn., retiring in 1950. It was under the presidency of Miss Turnbull that the A.C.H.A. launched its educational fund-raising campaign and, through this program, the various aims of the College were expanded. Miss Turnbull, a nationally known figure in the hospital field, was a Charter Fellow of the A.C.H.A. and its second vice-president in 1939; a former vice-president and trustee of the American Hospital Association; a member of the Red Cross Nursing Committee since its formation; and served as president of the Hospital Association of Pennsylvania, the Pittsburgh League of Nursing Education, the Pittsburgh Hospital Conference, and the Pennsylvania State Nurses' Association.

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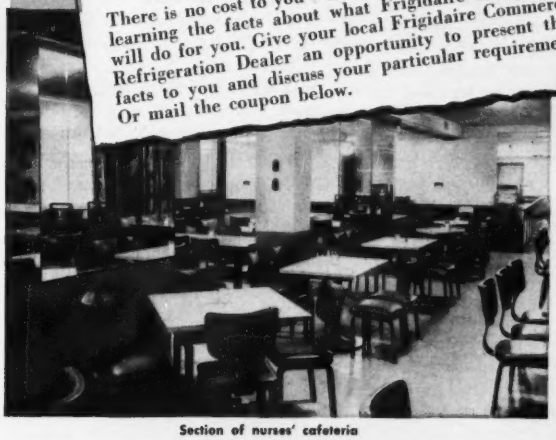

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## Presidential Report

*(Concluded from page 68)*

surer. The secretarial reports will cover the various undertakings of the past two years and the Treasurer will acquaint you with the financial situation. My remarks have centred largely on questions of policy.

### Appreciation

I appreciate greatly the willing acceptance of so many responsibilities by other officers and by members of the executive. It must have appeared, at times, that I was avoiding personal obligations. My concept, however, of a strong and healthy organization is a "sharing of the burden". I am convinced that such a policy brings strength for the future.

Dr. Agnew, busy as he was with his consulting work, took over the chairmanship of the Committee on Education and his counsel, advice, and other assistance—so generously given — has helped solve many a problem.

We expected that Dr. Bradley and Mr. Ross would be able and efficient officials, but their initiative, enthusiasm, and ability has far exceeded our expectations. The entire hospital field has benefitted already from their efforts.

I would hesitate to mention other names, but it is clearly evident that we are indebted to other workers. The dignified and well-edited journal does not just appear without capable and conscientious effort. Neither does the library keep up-to-date without competent attention. It has been the same with the other permanent workers. There is harmonious team work at Council headquarters.

To other officers, to members of the executive, to Dr. Agnew, to the officers of the member associations, to Dr. Bradley and Mr. Ross, and to the loyal members of their staff there is a big—thank you. Also, I would like to express my thanks to the Sun Life Assurance Company for the continuing financial support which has done so much to raise the standard of care for our patients.

A new president will take over the responsibilities of office before the sessions of this meeting are completed. I know he will find an interesting, congenial, and important field to work in. I leave the office with a deep sense of appreciation of the values of the Council and a high regard for all associated with Council undertakings. ●

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## Rehabilitation

*(Concluded from page 27)*

tions, treatments, ward rounds, and private interviews are pointless unless the information obtained is made available to all. Staff attendance should be compulsory and, whenever warranted, representatives of outside welfare or rehabilitation organizations directly interested or sponsoring patients are to be invited for group planning and discussion. Schedules of activities must be drawn up to utilize the patient's time to best advantage. The schedule provides for treatments, education, counselling, diversion, and recreation. In this fashion, it is possible to determine where the patient is and what activity he is engaged in, at any time of the day.

On first consideration, it is impossible to visualize every general hospital with beds and space for a rehabilitation ward. However, if this could be possible, there would undoubtedly be an increase in the over-all turnover of patients and, at the same time, an outlet would be provided for active medical and surgical wards which are almost always overloaded with long-standing chronic cases. Surgeons and internists, in spite of their willingness, find it difficult to maintain interest in chronic cases because of the steady inflow of new patients requiring more urgent attention. The department of physical medicine rehabilitation is the logical service to initiate the full and complex rehabilitation program which will permit the patient's discharge to his family or convalescent home as soon as minimum independence has been gained. If indicated, rehabilitation centres outside the hospital climax the patient's reinstatement to society and gainful employment.

The majority of present cases reporting to rehabilitation centres are patients with long-standing chronic handicaps who have been discharged from general and convalescent hospitals. A review of the social service index reports show that most of these patients are on public relief and have been cared for by a number of welfare organizations. Consequently, complete rehabilitation is almost impossible. However, at times physical restoration is possible, but only at the cost of great effort and expense. Entire rehabilitation cannot be applied because, as stated by Letourneau* "in long-standing cases, adjustment to misery is so well established as to be permanently fixed in the mind and body of the handicapped person".

If rehabilitation departments were created in general hospitals, pre-discharge planning and prognosis would be facilitated. Then, only cases eligible for the scheme would be referred for further treatment, whilst unrehabilitable patients, with a maximum of independence and capacity for self-care, could be returned home or placed in institutions.

The back-log of unevaluated disabled persons in this country is immense. With present resources, their rehabilitation appears to be utterly impossible, and, as based on experience, it can only be achieved with poor results in the majority of cases.

The creation of rehabilitation sections in general hospitals would provide excellent teaching and training ground for students of all professions, directly or indirectly associated with rehabilitation. As so aptly pointed out by Dr. Howard A. Rusk (Professor and Chairman, Dept. of Rehabilitation and Physical Medicine, New York University College of Medicine, New York), this would be the only way of preventing the inevitable support of one disabled person by each able-bodied individual thirty years hence.

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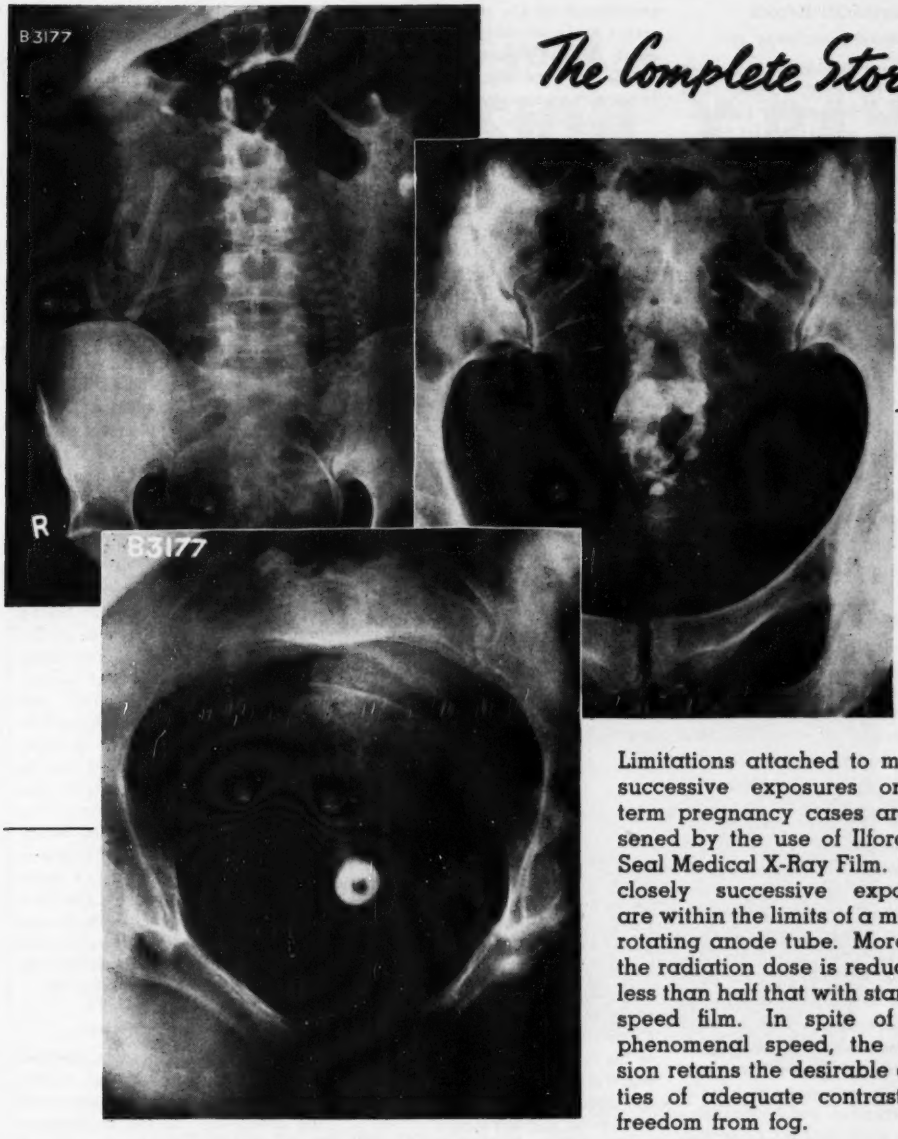
**Charles U. Letourneau, M.D., C.M., Chairman of the Technical Advisory Board of the Rehabilitation Society for Cripples. "Rehabilitating the Handicapped"—No. 1 of a series of educational booklets on Physical Medicine and Rehabilitation published by the Rehabilitation Society for Cripples in Montreal, Canada, 1951.*

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## Secretarial Report

*(Continued from page 36)*

heralded of our services, it is a major activity of the staff. There is a steady flow of requests for information, direction, materials and literature on every aspect of hospital and health service. In the past several years, the requests handled by the library increased remarkably and we may expect still wider use as the extension course develops.

### Program Advisory Service

The Council has always assisted in building institute and convention programs. From the records and experience accumulated, from the visits of one or more Council staff to nearly all of the Canadian and some of the American meetings, it is possible for program committees to draw upon resources from outside of the province and elsewhere when needed. This service is available for any group that wants it and we would like to see it used freely.

### Extension Course

The development of a larger and more active program in the field of education and training of hospital personnel has occupied a very substantial portion of executive time during the past 15 months. The accomplishments to date have been rather significant and will be reported upon and discussed fully by Dr. Agnew, Chairman of the Committee on Education. A major advance has been made possible through the generosity of the W. K. Kellogg Foundation, whose officers have given a great deal of time and interest and, to start the ball rolling, have made available a substantial grant.

It is important, also, to report the frequent and continuous requests for trained personnel in all categories as well as many inquiries about training opportunities and facilities. There is a great deal yet to be done in order that a steady and satisfactory supply of hospital personnel may be available.

### Liaison With C.M.A.

A close liaison has been maintained (and there have been many profitable conferences) with the Canadian Medical Association—our parent—before the Council baby grew big and vigorous enough to leave its roof. An example of this was the amendment of the internship application arrangements under the Canadian Interne Placement Service of C.A.M.S.I. Generally, there has been favourable comment on the new plan which seems to be working well. I saw recently a report of an American hospital administrator, now in charge of a Canadian hospital, who gave high praise to the scheme. There will be opportunity to discuss the matter when Dr. A. D. Kelly of the C.M.A. is present on Tuesday.

### Unemployment Insurance

As the result of Council activity at the time of the introduction of Unemployment Insurance in Canada in 1940, coverage did not include hospital employees. When in February, a year ago, it was indicated that coverage would be extended to hospital employees, the Council, acting in co-operation with the provincial associations, conferences, and governments, was able to secure a reprieve for our patients, who in the final analysis, would have to bear the cost.

The issue has been re-opened by the Unemployment Insurance Commission and the Council has again been active. The solution is not an easy one and will require further negotiation.

### Emergency and Disaster Services

In the years 1945 and 1946, there was widespread hope throughout the world that it would be unnecessary to devote much of our time and energy to war or preparation for war. There was a readiness to turn to rehabilitation and re-construction. There remain, however, certain malignant growths in the world that rule otherwise. The result is that again our planning is coloured by the world situation. Because officers of the Council did a notable job during World War II, governmental authorities have called on the Council for advice and assistance.

While present planning is aimed toward preventing dislocation of community health services, there is an increasing urgency about the preparations for emergency and disaster, particularly during the past six months. Your officers, both executive and secretarial, are beating a regular path to Ottawa to serve on two committees: Civil Defence Health Services; and the Defence Medical and Dental Services Advisory Board. I would like to add that in both fields the officials of the Departments of National Health and Welfare and of National Defence have consulted us frequently and kept us informed on all developments related to hospitals. The needs of hospitals have received fair and just consideration and we owe our thanks to these departments of government. There is yet another aspect of this topic that has involved the Council. The Canadian Red Cross, after careful review and research, has just completed a disaster organization across Canada. We were invited to attend the disaster institutes in Toronto and Winnipeg and, on May 1 of this year, participated in a 14-hour committee meeting to complete a very comprehensive manual on disaster organization. Hospital officials will be included in the medical and nursing aid committees in each area.

### Rehabilitation Conference

One of my most profitable experiences in recent months was taking part in the First Conference on Rehabilitation which was jointly sponsored by the Departments of Labour, National Health and Welfare, and Veterans' Affairs, in Toronto on February 1, 2, and 3 of 1951. A statement of rights or principles for the injured or handicapped citizen was worked out for presentation to the federal government. It was recommended, also, that a large representative Advisory Committee on Rehabilitation be constituted. The Canadian Hospital Council is to be one of the six National Health Agencies that will serve on the committee. The surface has barely been scratched.

### Conference on Statistics

The Council has been represented at the dominion-provincial conferences on hospital statistics and working committees of the conferences. Progress which has been made will be reported later in the meeting.

### Biennial Meetings

There is another observation that I should like to make. It arises from finding that, for lack of time, many important items had to be omitted from our agenda. The national picture and the provincial hospital situations are changing very rapidly because of present social trends. The

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hospital and their organized bodies are put to it to keep up with these changes. It would seem that one of two courses might be followed. We might either lengthen the biennial meeting to four days or have an annual meeting. There are many important issues at stake and they need very careful consideration and judgment.

### Editorial Report

It is a privilege now to report as Editor of the Canadian Hospital Journal. It can be brief since this work goes out each month in a green cover for your perusal. Under Dr. Agnew's guidance our publication acquired a very fine reputation as a professional journal both in this country and afar. Miss Fraser, Mr. Ross and myself, together, are trying hard to fill the last editor's shoes and are rapidly turning grey in the attempt. Mr. Edwards, the founder of our journal, continues his association with us and his counsel and guidance is much appreciated as is the quality of his management.

The pattern of journal development has been to expand and improve its services to the field and this has gone steadily forward. Recently, attention has been directed to featuring certain departments of special interest such as dietetics, construction, and pharmacy, and another is under consideration for October. Because of the obvious interest in construction, hardly an issue goes by without the story of a new hospital just opened somewhere in Canada.

It has been editorial policy to keep the spotlight on personnel since the need is greatest in this area. Much remains to be done.

### Journal Awards

The Editorial Board, for 1949 and for 1950, again awarded first and second prizes to authors who topped the field for the year. It was a pleasure to announce in 1949 that Agnes Tennant Johnson of Montreal won the first prize of $100.00, while Edythe Markstad, Reg.N., of Edmonton, was awarded the second prize. In 1950, Dr. Hoyle Campbell of Toronto and Dr. Malcolm Taylor of Regina took the 1st and 2nd prizes respectively. For excellent writing and content, there is an additional list headed "Honourable Mention" and these warrant careful reading by every trustee and administrator.

We may well summarize Dr. Agnew's comments in his 1949 report. There are many new ideas and developments in various parts of Canada that should be better known across this country and abroad. Yet our hospital people do not write for publication without persistent pumping, pampering or prodding. It's too bad, for there is so much of value to be reported. We would hope that contributions large and small and varied may pyramid into a plentiful supply of literary material in the near future.

### C. E. A. Bedwell

One of the most interesting special features of the journal "With The Hospitals in Britain" came to an end when our "Londoner," Mr. C. E. A. Bedwell, died suddenly in April 1950. Two letters, in our May and June issues of 1950, were published posthumously. His clear and dispassionate reporting gave vital information on the changing British health scene and his letters will have been missed by his many Canadian friends.

### Appreciation

The strength of any organization becomes apparent when it is subjected to stress. The transition from tried and experienced hands to new hands during the past two years has been effected without major incident because of very effective group action for which I must express my appreciation. You can feel proud of your executive committee, who tightened up the riggings and pulled on the oars like a well matched team. And you must be grateful to your President, who kept watch on the course and who steadied the tiller when it began to flutter. I want particularly to express my gratitude to the full-time crew who knew what was needed and put everything into its accomplishment. The last nine months have been a very strenuous period and have been survived only because the load was shared.

But there is another special word of appreciation that I should like to put into the record. It, too, can be included under the category of group action since there was a genuine interest in the well being of this whole group—the Canadian Hospital Council. I refer to a certain gentleman who permitted many consultations at lunch-time, and on numerous other occasions—on planes, and trains, in hotel rooms and up at his cottage, at home and far from home. When help was needed, help was available, and at no small sacrifice in time to the donor. Dr. Agnew's continuing interest and wise counsel have been invaluable. Nor does our appreciation and gratitude stop here. We have enjoyed a very positive relationship with the Ministers of Health and with the departmental officials at the federal level and at the provincial level. There has been continuous and active co-operation and a genuine readiness to work out what is best for the hospitals of Canada. We might speak of it almost as a partnership.

And in closing may we, at the Council, add that it has been a pleasure to be associated with the officers and members of the provincial associations and conferences. We have a common objective—better patient care—and we can think of no better company for this exciting journey toward that objective.

Respectfully submitted,

"L. O. BRADLEY,"

Executive Secretary.

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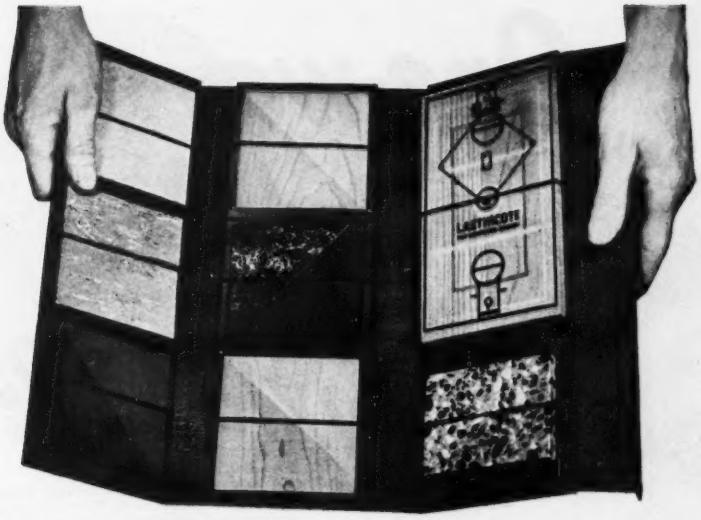
### Saskatchewan to Award Bursaries for Hospital Course

Two bursaries will be offered by the Saskatchewan Department of Public Health to provide post-graduate training in hospital administration for two residents of the province.

The bursaries will cover tuition, sustenance, travel expenses, and an allowance for books used during the academic year 1951-52, in courses leading to a diploma in hospital administration. To be eligible, students must be qualified for admission to one of the universities, in Canada or in the United States, offering these courses. They must also have one year's experience in a hospital or in related work.

Full information and application papers may be obtained from the Director, Division of Hospital Administration and Standards, Saskatchewan Department of Public Health, Regina.



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SR SEAMLESS

## New "K-W" Hospital

*(Concluded from page 35)*

time bacteriologist. There are two part-time pathologists.

### Dietary Department

A point of interest in this department is the milk division. Raw milk is delivered in large cans directly from farms under contract. At the hospital it is sterilized, homogenized, and placed in coolers ready for use. This system represents a very large saving to the institution.

The main kitchen is a large and airy department with windows on three sides and glassed-in office for the chief dietitian. The ceiling is finished in acoustic tile and all tile is in a soft shell tone. One of the most prized pieces of equipment is a marble-topped bake table. Patient trays are set up in the department and distributed to the floors by the "trayveyor" system

All stores are the responsibility of the purchasing agent with whom the dietitian places her orders for food. The large stores area is equipped with refrigerated sections, as well as the main kitchen.

There are two cafeteria-dining rooms, one for employees who do not wish to change from working clothes for the luncheon period, and a larger one for all staff and visitors. The second, which is placed conveniently near the main lounge and administrative offices, has windows on three sides of the dining area. The soft grey and green walls and chartreuse ceiling are enhanced by gaily coloured drapes.

### Use of Colour

The colour scheme, scientifically worked out and applied all over the hospital, is interesting and often surprising. Very little white appears and, where used, there is always a hint of colour in it. Beautifully blended pastels in innumerable variety are seen in patient rooms and nurseries—pink, mushroom, lavender, yellow, oyster, aqua, lime, and so on. Only their current names are much more subtle. The sections of wall near nurses' stations and about the elevator doors are painted in brilliant hues, e.g., cerise, raspberry red, wedgewood blue, and Hudson Bay green. These colours are definitely stimulating and their purpose is to help night nurses and attendants to stay alert through the trying hours before dawn. In this respect the scheme is somewhat experimental.

### Construction

As can be seen by the illustrations, the hospital is a Y-shaped building, connected by corridors to the earlier hospital. It has a structural steel frame, bar joist construction, with concrete slabs and exterior curtain walls of red brick masonry. Beams are fire-proofed with concrete, and columns with tile and brick. The walls are insulated with 1½" fibre glass and have inside furring of 4" tile and plaster. The roof has 1½" insulation.

Floors are of terrazzo throughout except in the corridors where rubber tile has been used. Operating room floors are of conductive terrazzo and walls are of glazed tile, while central supply and kitchens are finished throughout with structural glazed tile. For the sake of quietness in the corridors, perforated fibre tile is used on the ceiling.

Windows comprise two-thirds of the exterior linear length of the building, to provide plenty of light and air. A pivot window has been used which is double-glazed and reversible, hence no human flies need be engaged for window cleaning. This type of window can also be used as a no-draught ventilator. Windows are screened on the lower floor only. The building is heated by forced hot water with recessed convector radiators which take no room space.

An audible doctors' paging system has been installed and patients use a push-button arrangement to call a nurse. It is expected that an inter-communication system between patients' rooms and nurses' stations will be installed later.

A pneumatic tube system with an exchange station on the first floor serves the whole hospital. Tube entrances are in all nursing stations and in the various service departments. By this means items such as charts, doctors' orders, notices of admission and discharge, menus, requisitions, and laboratory specimens can be dispatched at a high rate of speed.

Operating rooms are fitted with television conduits which, it is hoped, will come into use later. There is a plentiful supply of oxygen outlets throughout the patient areas.

Architects for this one-jump-ahead hospital were the firm of Govan, Ferguson, Lindsay, Kaminker, Maw, Langley, and Keenleyside, Toronto.

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### O.M.A. to Ask Extension of Medical Care for Welfare Groups

In a recent release from the Ontario Medical Association, Dr. E. K. Lyon, of Leamington, president of the Association, stated that the Ontario government would be asked to extend medical care for welfare groups to include medical care in hospital. The decision was made by the general council of the Association. Home and office medical care for welfare patients is provided by Ontario doctors, at present, through a unit of the O.M.A., the Medical Welfare Plan, which uses funds turned over to it by the government. Medical care in hospital for these patients is now provided by doctors without charge. Those entitled to treatment through the Medical Welfare Plan are old age pensioners and recipients of mothers' allowances, blind allowance, and relief.

Dr. Lyon also stated that doctors would be willing to accept on Medical Welfare Plan lists of pensioners who are eligible for the expanded old age pension benefits proposed by the federal government, provided these people "are adjudged to be in economic need". Since the new pension group will probably include all persons over 70 years of age without a means test, the resolution indicates that doctors are willing to extend the welfare plan only to the needy patients in the new group.

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### Approval Program Available

The revised official approval program for Blue Cross hospital service plans, as adopted by the House of Delegates of the American Hospital Association on September 17, 1950, is now available. This approval program supersedes all previously published statements. Copies may be obtained from the American Hospital Association, 18 East Division St., Chicago 10, Illinois.

## Federal Health Services

*(Concluded from page 41)*

health, mental health, nutrition, dental health, child and maternal health, venereal disease control, blindness control, hospital design, and epidemiology.

To bring the story of health more effectively to every Canadian man and woman, boy and girl, the information services division of the department produces, for distribution through the provinces, a vast amount of informational and educational material. Books and folders, periodicals, posters, films, filmstrips, displays and radio programs, designed to create a greater understanding and a keener awareness of the value of personal health and public health programs, are made available.

Also of importance in the Canadian health picture are special functions inherent in the operations of other federal departments such as the extensive treatment and rehabilitation programs for war casualties of the Department of Veterans Affairs; and services for health maintenance in the departments of agriculture, citizenship and immigration, fisheries, justice, labour, trade and commerce, resources and development, transport and national defence. The National Research Council, too, is of tremendous importance in advancing the frontiers of medical knowledge. As Canada's "national bookkeeper", the Dominion Bureau of Statistics of the Department of Trade and Commerce, plays a unique role in the health drama, particularly through the services performed by its vital statistics division.

### National Health Program

Perhaps the greatest health measure ever undertaken on a national scale in this country was the introduction of the National Health Program, administration of which is handled by the Department of National Health and Welfare through its directorate of health insurance studies.

Acclaimed internationally as an event memorable in public health, and representing the first stage in the development of a comprehensive health insurance plan for all of Canada, a program of grants, now totalling more than $34,000,000 annually, was launched by the federal government in May, 1948. Its primary purpose is to help the provinces initiate new health programs and extend their present health promotion and conservation facilities. Grants are available on the understanding that present provincial expenditures in each field are not decreased, thus guaranteeing an over-all increase in total health services.

The program consists of three types of grants — health survey grants, public health grants, covering a variety of health fields, and hospital construction grants. Except for the money to be applied to public health research, which is dispersed on a nation-wide scale on recommendation of the Dominion Council of Health, grants are allocated to the provinces for the most part on a per capita basis with special provision for smaller provinces.

Under the health survey grants, the provinces have been assisted financially in studying their health services and their hospital needs.

The hospital construction grants have been designed to encourage the provision of more than 40,000 badly needed beds within a five-year period. The grants, totalling $13,350,000 annually, apply to the construction of hospitals and nursing units or to additions to existing buildings commenced on or after April 1, 1948. The grants themselves are contingent on the province concerned at least matching the federal contribution. It is encouraging to note that, after two years of the program, federal aid has been approved for 25,000 new beds. In no fewer than 120 communities, hospitals are being established for the first time.

Public health grants are of eight different types: general health, tuberculosis, mental health, cancer, venereal disease, care of crippled children, professional training, and public health research.

The general health grant is designed to strengthen public health services generally, to assist in controlling communicable disease, and to develop such programs as those initiated in the field of child and maternal health. Tuberculosis control grants are expected to enable the provinces to extend areas of free treatment, and to accelerate the drive to wipe out the disease.

The purpose of the mental health grant is to encourage the training of professional personnel, and to help staff and equip new hospitals and clinics. The cancer grant of $3,600,000 is available for approved programs of cancer diagnosis, treatment and research, provided the province matches the federal contribution. Former federal contributions to the dominion-provincial campaign against venereal disease have been more than doubled.

Crippled children's grants are enabling the provinces to make modern diagnostic evaluation and treatment facilities more readily available to children crippled by accident, disease or inherited defect. Professional training grants have made possible the employment of nearly 2,500 more full-time health workers and some 360 part-time workers. The public health research grant is doing much to stimulate and develop research in various health fields.

Combined, these grants represent an outlay equal to the sum spent by the federal government on public health in the whole preceding quarter century.

### World Health and Welfare

Canada, as a nation, is also a powerful constructive agent in the sphere of world health. Through participation in and adherence to international conventions, she has made significant contributions to raising world standards and has given her representatives that broad experience and perspective which enhances their qualifications for leadership in domestic fields. As the first nation to deposit the instrument of ratification to the constitution of the World Health Organization, the Dominion has continued to play a major role in the global activities of WHO. Not only is Canada striving to provide a healthier and more secure existence for her own citizens, but she is also contributing her share to the advancement of health and welfare throughout the world.

Canada is also a member of the Economic and Social Council of the United Nations, of the Council's Social Commission, and of the International Children's Emergency Fund.

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***Indicated*** **in an inclusive list of bacterial, rickettsial and protozoan infections, e.g.: lobar pneumonia, bacteremia; erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; urinary tract infections; peritonitis; otitis media; skin infections.**

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*Capsules:* 250 mg., bottles of 16 and 100; 100 mg., bottles of 25 and 100; 50 mg., bottles of 25 and 100.

*Intravenous:* 10 cc. vial, 250 mg.; 20 cc. vial, 500 mg.

*Oral Drops:* 2 Gm. with 10 cc. of diluent, and calibrated dropper.

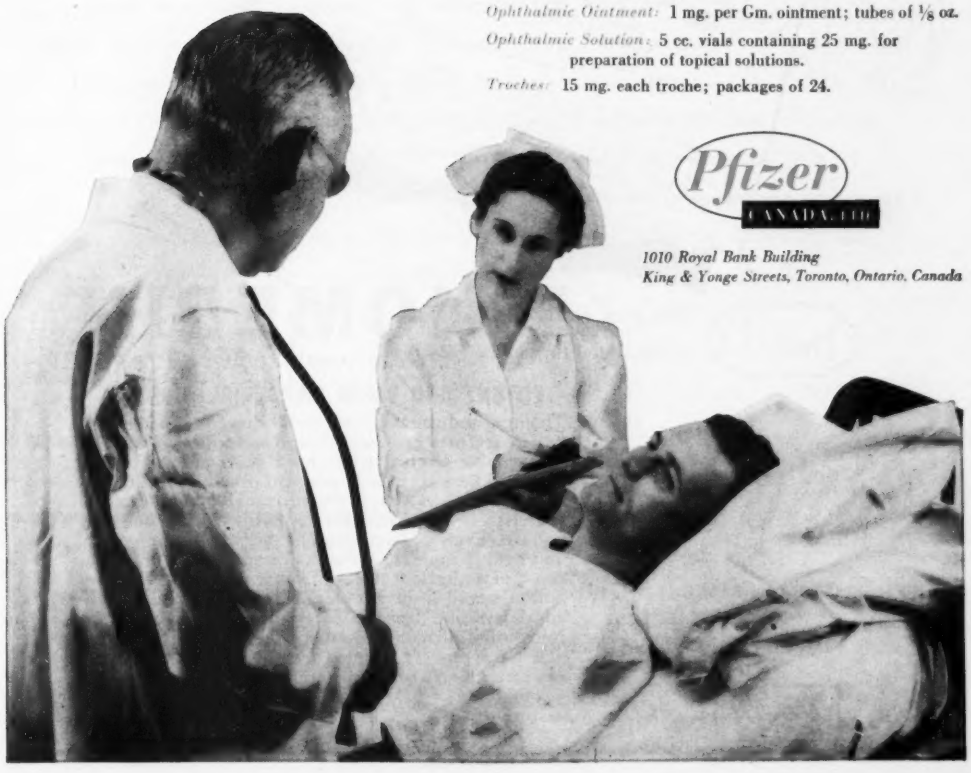
*Elixir:* 1.5 Gm. with 1 fl. oz. of diluent.

*Ointment:* 30 mg. per Gm. ointment; tubes of ½ oz. and 1 oz.

*Ophthalmic Ointment:* 1 mg. per Gm. ointment; tubes of ⅛ oz.

*Ophthalmic Solution:* 5 cc. vials containing 25 mg. for preparation of topical solutions.

*Troches:* 15 mg. each troche; packages of 24.



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Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

R. T. STOMMONT, M.D., Secretary.

**MERCAPTOMERIN SODIUM.—Thiomerin Sodium** (CAMPBELL PHARMACEUTICAL CO.).—Disodium salt of N(7-carboxymethylmercaptomercuri-β-methoxypropyl-camphoramic acid.—$C_{16}H_{23}NNa_2O_8S$.—M.W. 606.03.—The structural formula of mercaptomerin sodium may be represented as follows:

*Actions and Uses.*—Mercaptomerin sodium is an effective mercurial diuretic which produces much less local irritation on injection than other organo-mercurial compounds used for this purpose. It is also less toxic to the heart than the previously employed mercurial diuretics. It shares the other actions of these compounds and likewise manifests the potential toxic effects of mercury. Preliminary acidification of the urine also sometimes enhances its diu... Test. See the general state... [illegible] on Mercur...

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**If necessary Thiomerin may also be administered intramuscularly or intravenously.**

***Supplied*—10 cc. with diluent**

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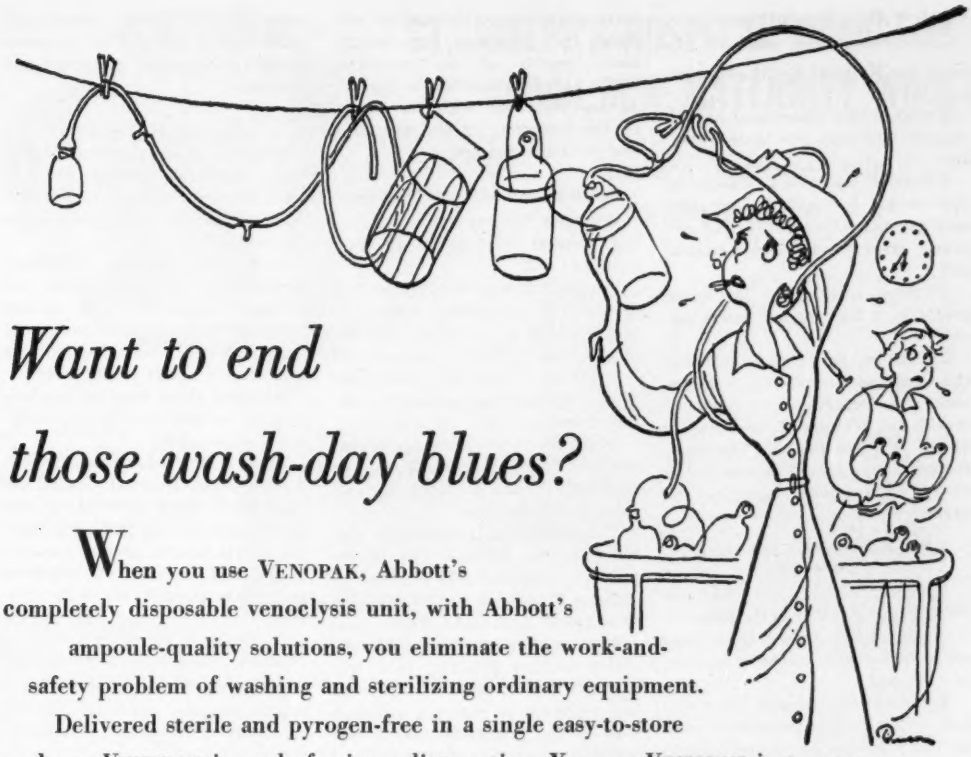

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**• No Cleanup**

Following infusion, throw away the entire unit, the container and the VENOPAK.

**ABBOTT'S completely disposable Venoclysis unit*

## C.H.C. Resolutions

*(Continued from page 50)*

lished the National Health program; and

WHEREAS this department has developed this plan for three years; and

WHEREAS the sound wisdom of this action is becoming apparent each day as health facilities and programs are expanded and initiated; and

WHEREAS each citizen in Canada profits by a high quality health service;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the Department of National Health and Welfare on the progress of the National Health Program to date and urge that it be established as a continuing and expanding program.

### National Health Consultative Committee

WHEREAS the Minister of National Health and Welfare established a National Health Consultative Committee to act in an advisory capacity to him; and

WHEREAS the various provincial and federal organizations involved in the provision of preventive and curative health services remain ready and willing to co-operate in the attainment of higher health standards;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council renew its offer of co-operation and assistance and express its regret that greater use has not been made of the National Health Consultative Committee.

### Health Survey Grant

WHEREAS all provincial hospital organizations and the Canadian Hospital Council contributed a great deal of time and energy to and participated in Provincial Health Surveys; and

WHEREAS there is a wealth of factual data and other material that has been collected and prepared; and

WHEREAS a substantial amount of federal money, which is secured from the community, has been expended;

THEREFORE BE IT RESOLVED that the provincial governments and the federal government publish and make available, at the earliest moment, the individual and consolidated reports of the provincial health survey committees so that all parties concerned with the health of the Canadian citizen may take new direction and action.

### Building Materials and Supplies

WHEREAS there is still a substantial hospital construction program in effect; and

WHEREAS it may be expected that there will be a significant increase in the building of facilities for the housing and training of nurses; and

WHEREAS an adequate health service is a front-line community defence; and

WHEREAS the short supply of certain building materials and supplies may impede the building of adequate health facilities;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its concern to the Minister of Defence Production and the Minister of National Health and Welfare and request that the most favourable consideration and priority, consistent with the defence needs of this country, be given to ensure a sufficient flow of the required building materials and supplies to the hospital construction program.

### Hospital Equipment and Supplies

WHEREAS a major portion of technical equipment and supplies for hospital and medical care is secured outside of Canada; and

WHEREAS much technical equipment and supplies are manufactured in Canada; and

WHEREAS the manufacturers of these articles in other countries and Canada require a sufficient flow of raw materials to produce these vital articles; and

WHEREAS imported and Canadian-manufactured equipment and supplies are required to equip new hospitals and to maintain service in established units; and

WHEREAS the quality of hospital care is dependant upon modern equipment in good operating condition;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge the Minister of Defence Production to make the necessary arrangements in Canada and with foreign governments, that will permit a steady and uninterrupted delivery of necessary hospital and medical equipment and supplies.

### Training of Personnel

WHEREAS the Department of National Health and Welfare has provided for the training of hospital personnel under the professional training grant; and

WHEREAS the shortage of qualified personnel in all professional and technical capacities is a serious handicap to the fine structure of health services envisaged by the federal government itself; and

WHEREAS there remains a handicapping limitation in training facilities and programs;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council recommend to the Minister of National Health and Welfare that all avenues and efforts to train greater numbers of hospital personnel be explored and, where possible, action be initiated.

### National Nursing Study Committee

WHEREAS hospitals and other health services requiring nursing personnel are rapidly expanding; and

WHEREAS present facilities for training nurses in all categories are steadily falling behind the expansion of other hospital and health facilities and services; and

WHEREAS there is an inexorable increase in the shortage of nursing personnel;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council encourage and co-operate with all parties concerned in initiating a study that will give some direction to a combined effort to correct or ameliorate the situation before it is too late.

### Nursing Assistants

WHEREAS the Canadian Hospital Council appreciates all that has and is being done to assist in educating nursing assistants (or practical nurses in some provinces) by the federal government under its vocational training program; and

WHEREAS it is the present policy of the federal government to confine its assistance to unemployed persons; and


# ST. JOSEPH'S HOSPITAL, HAMILTON ADDS NEW MATERNITY WING

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★ The new Maternity Wing of St. Joseph's Hospital, Hamilton, is an impressive example of modern planning interpreted in terms of *efficient* facilties.

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In St. Joseph's new Maternity Wing . . . and in 30 other Ontario Hospitals there are over 700 Metal Craft Nursery Cubicles! In every case such features as the extra safety of completely framed *plate* glass and the extra efficiency of sound-deadened double panels and easy-lift fold-away door on linen holder were the deciding value factors.

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WHEREAS the hospitals of Canada can use a much larger number of these nursing personnel;

THEREFORE BE IT RESOLVED that the federal government be requested to extend its assistance to all individuals who desire to take advantage of such training.

### Civil Defence

WHEREAS the principle of local, regional, provincial and federal co-ordination and integration of all community services, including hospital services, is recognized as fundamental; and

WHEREAS the need for leadership from higher authority is vital in the establishment of standards that are interchangeable between communities; and

WHEREAS the community hospital will be more than ever the health centre for emergency or disaster health service;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the federal government on the sound and careful approach being taken and exhort all hospital organizations at all levels to give the utmost co-operation to the civil defence authorities for the development of a strong and well prepared organization.

### D.M.D.S.A.B.

WHEREAS the Minister of National Defence has established the Defence Medical and Dental Services Advisory Board to advise on manpower in the health field and on facilities, equipment and supplies for hospital and medical care; and

WHEREAS the Canadian Hospital Council is desirous and ready to collaborate in any manner possible to ensure co-ordination of civilian and military hospital and health needs in the event of a national emergency;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the Minister of National Defence on the establishment of this Board and, further, that the Council assure the Minister of National Defence of the full co-operation of the Council in any plan designed to provide efficient co-ordination and integration of civilian and military hospital services in the event of a national emergency.

### Payment by Governments

WHEREAS in all provinces of Canada there is statutory provision whereby provincial and/or municipal governments are required to provide hospital care for indigents; and

WHEREAS in some localities there is a tendency for governments to expect hospitals to provide hospital care for indigents on a sub-cost basis; and

WHEREAS hospitals are criticized for showing deficits which, not infrequently, result from assuming responsibilities which are governmental;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council endorse the principle of federal, provincial, and municipal bodies paying the currently existing basic ward hospital rates and the currently existing hospital schedules for extras on behalf of patients admitted on authority from federal, provincial, and municipal governments.

### Dr. Frederick W. Routley

WHEREAS the late Dr. Frederick W. Routley, who died on February eleventh last, was an eminent leader in hospital organizations and endeavours, and took active part in the formation and development of the Ontario Hospital Association, and of the Canadian Hospital Council; and

WHEREAS his "genial personality, firm handclasp and friendly smile" brought him the "respect, admiration and warm affection of thousands of true friends";

THEREFORE BE IT RESOLVED that the Canadian Hospital Council again express its appreciation of Dr. Routley's life-work which gave so much to the people of Canada and the world.

### Community Relations

WHEREAS the maintenance of good community relations will permit and stimulate a high quality of hospital service;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge its member hospitals to review and enrich their public relations activity and to participate in regional and provincial programs so that the patient may be better served.

### Support of Blue Cross

WHEREAS the Blue Cross Plans have provided people with an effective means of prepayment protection against the eventuality of illness and hospitalization by participation in a co-operative prepayment plan; and

WHEREAS it is deemed desirable that the principle of individual enterprise and individual responsibility should be supported;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council continue to co-operate with and support Blue Cross organizations in every manner possible.

### Contributory Health Insurance

WHEREAS, in the opinion of the Canadian Hospital Council, the individual should be encouraged to regard the costs of illness and hospitalization as a personal responsibility to the highest degree possible; and

WHEREAS, in the opinion of the Canadian Hospital Council, the principles of compulsory taxation for hospitalization, and state control of hospitals are not in the best interests of either patients or hospitals;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge strongly that in the event the federal government deems it advisable to institute a plan for health insurance, that such a plan be established on a contributory basis.

### Voluntary Hospitals

WHEREAS the voluntary hospitals of Canada have served the people of our country faithfully and well, since 1639; and

WHEREAS in the opinion of the delegates of the Canadian Hospital Council presently assembled, the best interests of the patients and our hospitals can be perpetuated by continuing the democratic, voluntary management of hospitals;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council go on record as viewing with concern any influence or trend which weakens the principle of democratic, voluntary, management of hospitals.

---

One hundred thousand people were given transfusions of free whole blood or plasma supplied by the Red Cross during 1950.

# Back-Guard

**the ideal mattress and matching box spring for extra firm support**

Simmons Back-Guard is especially designed for anyone with back trouble who needs almost unyielding support, or for those who prefer a good firm mattress. The matching box spring provides an additional platform to the Back-guard mattress. Available in all standard sizes—Simmons precision "auto-lock" spring unit—all-felt upholstering — decorative metal handles for easy turning.

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## Maritime Hospitals

*(Continued from page 43)*

Toronto, spoke on "Oxygen Therapy". Various panels were also conducted throughout the meeting and two motion pictures were shown. Geriatric problems were examined by Rev. Sister Stanislaus, Charlottetown; and Dr. G. E. Mathews, Victoria General Hospital, Halifax, dealt with the subject of medical records.

### Resolutions

The Association passed a resolution in favour of establishing a national committee to study the nurse shortage problem. The committee is to be composed of representatives of all interested parties, with sub-committees being established at provincial levels. Committees were empowered to continue their work until a solution of the problem is reached. A resolution was also passed asking the Canadian Hospital Council to commend the Minister of National Health and Welfare on the action of extending financial aid for the construction of nurses' residences, laboratories, and out-patient departments.

In connection with Unemployment Insurance Coverage, the Association resolved that, while not opposing the principle of Unemployment Insurance, it would go on record as opposing, under the present system of hospital financing, the extension of Unemployment Insurance to employment in hospitals.

Resolutions were passed to be referred to the proper government departments concerning the hospitalization of Indians in general hospitals on the basis of the per diem cost for ward service; requesting that the most favourable consideration and priority, consistent with the defence needs of this country, be given to ensure a sufficient flow of required building materials and supplies to the hospital construction program; urging the Minister of Defence Production to make necessary arrangements to ensure a steady and uninterrupted delivery of necessary hospital and medical supplies; and commending the Department of National Health and Welfare on the progress of the national health program to date, while urging that it be established as a continuing and expanding program. In respect to health surveys, it was resolved to request that the provincial governments table in the provincial legislatures, at the earliest moment, the report of the provincial health survey committees so that all parties concerned may take new direction and action.

Resolutions were passed, pledging the co-operation of the Association with Blue Cross organizations, and with organizations representing the medical profession. Another resolution urged member hospitals to review and enrich their public relations attitude and to participate in regional and provincial public relations programs.

Appreciation was expressed in resolutions to the Sun Life Assurance Company for its valuable support; to the W. K. Kellogg Foundation for its assistance to the Canadian Hospital Council in the development of training programs for hospital personnel; to the Maritime Hospital Exhibitors' Association, who were also commended for their efforts in establishing a constitution, by-laws, rules and regulations to govern the con-

## Maritime Hospitals

*(Concluded from page 88)*

duct of their organization; to all those who contributed to the success of the convention—the speakers, exhibitors, management and staff of the Algonquin Hotel, and the press and radio for their coverage; and to the retiring president and executive committee for their constant and untiring efforts.

### Officers Elected

Executive officers elected for the coming year are as follows:

*President:* Neil MacLean, Charlottetowne, P.E.I.

*First Vice-President:* Dr. O. C. MacIntosh, Antigonish, N.S.

*Second Vice-President:* Col. Leo. D. MacDonald, Charlottetown.

*Third Vice-President:* R. H. Gale, Saint John, N.B.

*Secretary-Treasurer:* Mrs. Gladys M. Porter, Kentville, N.S.

*Executive Members:* Rev. M. J. McKinnon, Glace Bay, N.S.; Andrew Likely, Charlottetown; Rev. Mother Ste. Therese, Bathurst, N.B.; and Major Mable Crolly, St. John's, Newfoundland.

*Representing Hospital Aids:* Mrs. James Ross, Truro, N.S.

*Representing Exhibitors:* E. J. Holland, Halifax, N.S.

## Dietary Service

*(Continued from page 56)*

suitable types of food served to bed patients.

In many instances little planning has been done in the selection of equipment or its layout. There has seemed to be a tendency to regard the kitchen equipment as being something that can be utilized until it literally falls apart, whereas a relatively minor investment might greatly increase efficiency.

### Purpose

In planning the work of the dietary consultant two purposes were kept in mind—first to improve the quality of food and efficiency of service and secondly to assist hospitals to evaluate and control their food costs. Before commencing actual visits to hospitals certain materials were prepared. These included a temporary diet manual listing routine hospital diets, also lists of equipment for various sized hospitals. As the service progressed, copies of suggested adequate menus, standardized recipes, and simplified food costing forms were supplied.

Experience has proven that the maximum results can be obtained by personal visits to hospitals. Actually seeing the problems in the food service department in a particular institution makes it much easier to be of assistance than attempting to handle these problems by correspondence. Then, too, discussion with the doctor, the hospital administrator, and the cook, brings to light many problems that might otherwise be overlooked. In many cases solutions to problems are provided by the personnel concerned, with the consultant merely acting as a catalyst, bringing the points of view out into the open.

Since the establishment of the service in 1949, more than half the hospitals in the province have been visited. To the majority of these return visits have been made and, in some instances, two or even three follow-up calls made. Specific requests from hospital administrators for the service are given immediate attention.

The length of time taken for each visit varies greatly and is entirely dependent on the problem or prob-

lems involved. In some cases, the length of time spent may be only a few hours. Generally speaking, the average visit takes one or two days but in one of the large hospitals it developed into a two-week stay.

Follow-up visits have almost always shown an improvement in food service although in a few instances the results have been disappointing. There are times when a second visit means meeting an almost new staff —and a virtual repetition of the original visit. The fact that an interest is shown by an agency outside the hospital has a very salutary effect on the morale of the kitchen staff. With only one or two exceptions the visit from the dietitian has been welcomed by the kitchen staff. In those few exceptions there was evident friction between the cook and the administration of the hospital; and in all likelihood the visits were regarded as an interference.

### Reporting a Visit

On the actual visit to the hospital the consultant makes her first contact with the administrator or nurse-in-charge of the hospital. Food service is discussed in general with the administration, giving particular attention to purchasing policies at this level. From there the contact continues with the cook and the kitchen staff.

On the completion of the hospital visit a report is made covering various conditions in the dietary department. Record is made of the number of meals served to patients and staff, the amount of equipment, and the general layout of the food service area. A short narrative report is also completed which sets down the facts concerning food service, together with recommendations for improvement. A break-down of raw food costs is included with the narrative. A copy of this report is sent to the hospital for the guidance of the administration.

### General Aspects

Since the nutritional content of meals is often neglected, planning menus is stressed. In small hospitals there seems no advantage in planning more than one week in advance. To stimulate interest and action, the Nutrition Division supplies menu forms to all hospitals desiring them. Complementing this is the need for standardized basic recipes. Their use tends to reduce waste and makes good results more likely. These, too, are provided where the need exists.

Particular attention is paid to the manner in which food is served. Not only is the attractiveness of the tray stressed but emphasis is placed on the need for serving hot foods hot and cold foods cold.

Food costing is one of the most difficult procedures to institute in smaller hospitals. In fact it has been found difficult to convince some of the larger hospitals of its desirability. Certain types of foods are unsuitable for hospital purchase particularly with regard to size and quality. A simplified food cost accounting manual has been worked out and is applicable to all hospitals regardless of size. This has been used successfully in many hospitals and allows the administration to keep at least a monthly check on his meal costs. It also permits the calculation of the portion of the food budget spent on various food groups.

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It is anticipated that the use of this accounting system will be more general in the province as the advantages of accurate costing become better realized.

The problem of therapeutic diets has been a most difficult one for the smaller hospital to solve. Many hospitals have no accepted diet manual; and often their only references are a few miscellaneous and outdated diets which have been collected through the years. The need for a generally acceptable diet manual is very evident; this need has been partially met with a temporary manual. It is hoped to have this revised and accepted by physicians in the near future.

The organization of duties and time of the dietary staff has been another frequent task of the consultant. It involves the actual listing of duties and planning of work schedules. In many cases it has been possible to iron out frictions which have arisen in the department and are traceable to lack of knowledge of duties and responsibilities.

Many other aspects of proper dietary management are discussed with the staff when visits are made. These include such problems as general sanitation, housekeeping in the kitchen, dishwashing techniques, personal appearance of the staff, food storage and garbage disposal. Since infant formulae are part of the dietary department, considerable attention is paid to this problem.

As mentioned previously some hospitals have many problems, some have few. The encouraging factor is that hospitals in general welcome the service. Doctors are relieved to have clear-cut diets and charge nurses appreciate knowing that help is available. Administrators welcome suggestions for reducing food costs and simpler means of calculating them. Cooks welcome the interest and concern in their work. It builds their morale and gives them more pride in their part of patient care. The majority of hospitals have welcomed the assistance and have signified by letters and gestures their gratitude for co-operation in helping them to provide better food service.

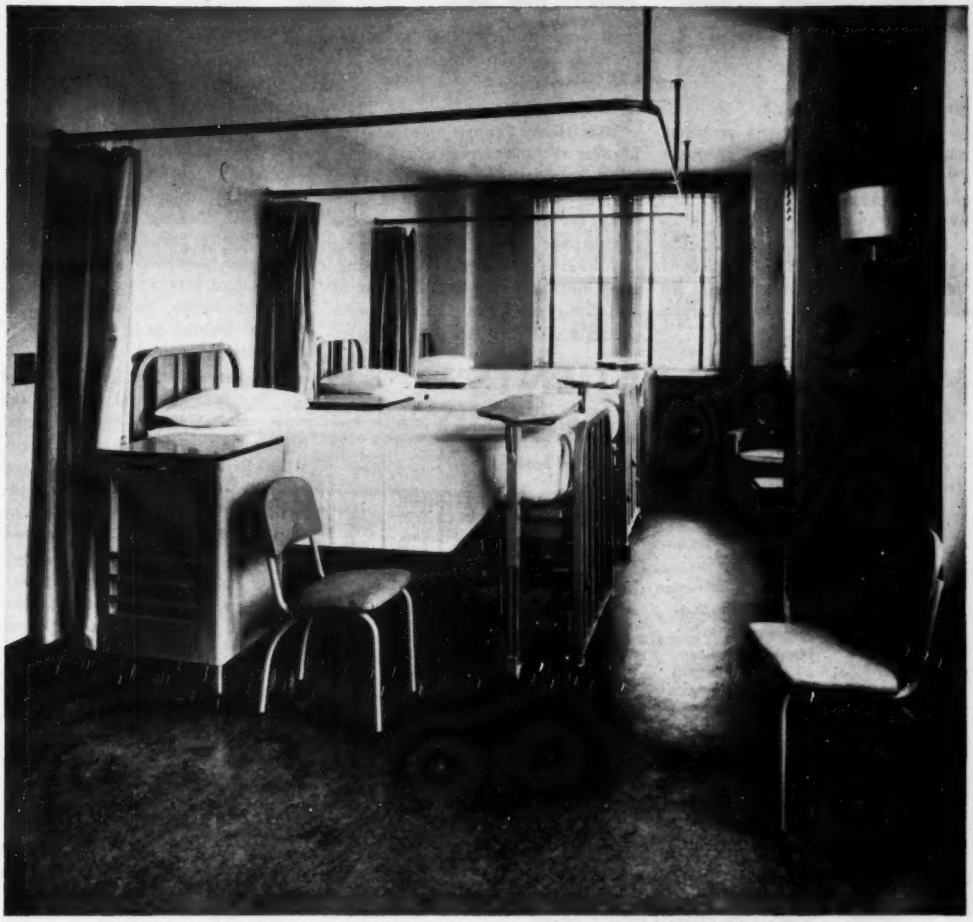
Much progress has been made in these past 20 months of providing consultative dietetic service to small hospitals. In fact, the service has proved itself so successful that steps are now being taken to employ a second travelling dietitian. What has been accomplished is, however, but a beginning—much remains to be accomplished. Still greater improvements can be effected in the dietary departments of the small hospitals which cannot employ a full-time, qualified dietitian. The goal is efficient food service in all hospitals—tasty, attractive, nutritious meals at reasonable costs. The past is encouraging, the future is challenging!

---

A new motion picture company was formed. It was decided to call it the Miracle Film Company.

"We'll get a big sign," said the boss. We'll get the biggest sign in the world so it can be seen for miles. We'll spend five hundred thousand dollars for a slogan on it."

So, after spending all that money on the sign here's how it read: *If It's a Good Picture, It's a Miracle.—Davis' Nursing Survey.*



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## Western Canada Institute

*(Continued from page 45)*

Adshead of Edmonton.

Paul D. Shannon, assistant secretary of the Manitoba Hospital Association, spoke of the problems inherent in producing adequate accounting results in small hospitals, and made suggestions for overcoming these problems. The progress that has been made to standardize accounting and statistical records was reviewed by Murray Ross. He also mentioned that the Canadian Hospital Council will publish a hospital accounting manual as a co-operative project of government and hospital representatives.

### Nursing

Miss Helen Penhale, professor of nursing at the University of Alberta, gave a very informative paper on nursing service and education, centring her discussion chiefly on the future role of the graduate nurse in bed-side, general duty nursing. Miss Margaret G. Lang, director of dietetics at the University of Alberta Hospital, spoke on the need for making the services and advice of dietitians available to hospitals, particularly to the smaller institutions in rural areas. This led to very useful discussions on the sharing of services among hospitals, on regional planning, and on the role of advisory consultants in specialized services. Dr. O. C. Trainor, Winnipeg, emphasized the need for extending diagnostic services, including the consultative services of pathologists and radiologists, to every general hospital wishing to be recognized as a "modern" hospital.

The eleventh biennial meeting of the Canadian Hospital Council was reviewed by Edgar Dutton, Lethbridge, Alta., and Frank Swain, High River, Alta. The work and activities of the Council during the past two years were described by the associate secretary, Murray Ross.

Utilization of facilities at the University of Alberta for exhibits, lectures, as well as residence accommodation, proved to be highly popular. Delegates were prompt in their attendance at the lectures which commenced at 8.30 a.m., showing the same interest and enthusiasm through each and every session. What may have been lacking in social activity was certainly made up for by the increased concentration on the subject matter of the Institute and the experience of living in a scholastic atmosphere and beautiful surroundings.

The huge gymnasium, a former R.C.A.F. drill hall, was partitioned to provide a lecture hall at one end, leaving most of the floor area for commercial displays. Exhibits of hospital supplies and equipment, always an outstanding feature of the institutes, were particularly attractive. Their representatives were kept very busy between lectures, demonstrating and explaining their products.

Arrangements at the University proved to be so satisfactory and were received with such unanimous enthusiasm that the co-ordinating committee recommended that, whenever possible, this practice be perpetuated.

The co-ordinating committee, representing the four western provincial hospital associations, held its

*(Concluded on page 104)*

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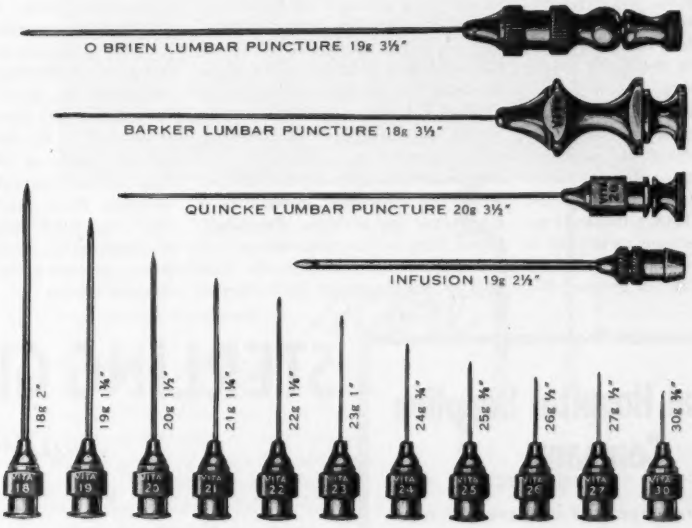


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### Les Service de Santé

*(Suite de page 41)*

ports interprovinciaux, et caetera.

Le ministère fédéral de la Santé, chargé de ces fonctions, est aussi autorisé à venir en aide aux provinces en faisant des enquêtes et des recherches sur les problèmes de santé publique ainsi qu'en collaborant avec elles dans le but de protéger et d'améliorer la santé publique, car, constitutionnellement parlant, les services de traitement et de santé sont d'abord du ressort des provinces.

Il met également à la disposition des provinces des services d'information très développés, qui comprennent des livres, des périodiques, des plaquettes, des films, des projections fixes, des étalages, des aides éducationnelles, et caetera.

Ajoutons que plusieurs autres ministères fédéraux offrent aussi à la population canadienne des services de santé nationaux.

Le Programme national d'hygiène, proclamé en mai 1948, a inauguré un régime de subventions, s'élevant à plus de 34 millions de dollars par année et constituant le premier élément d'un vaste régime d'assurance-santé pour tout le Canada, subventions destinées à aider les provinces à étendre et à perfectionner leurs services de santé.

Les principaux objectifs de ce Programme sont (a) de procéder à des relevés et à des enquêtes: des fonds sont accordés à chaque province pour lui permettre de recenser ses services d'hygiène, d'évaluer ses besoins en aménagements hospitaliers et d'organiser de nouveaux services de santé; (b) d'amplifier les services d'hygiène; subventions destinées à favoriser l'établissement de nouvelles entreprises, à accroître les services sanitaires, à stimuler les recherches en matière d'hygiène publique, à former des hygiéntistes, à aider les enfants infirmes, à lutter contre la tuberculose, le cancer, les maladies vénériennes et les maladies mentales, et (c) de multiplier les amenagements hospitaliers: aide à la construction d'hôpitaux en vue d'assurer 40,000 lits absolument nécessaires et d'accroître les services d'hospitalisation dans tout le Canada.

Plusieurs de ces objectifs sont déjà en bonne voie de réalisation et on est déjà en mesure de constater, par tout le pays, les résultats bienfaisants du Programme national d'hygiène.

Le Canada aide au progrès de la santé dans le monde en souscrivant à des ententes internationales et en participant activement aux travaux de l'Organisation mondiale de la santé.

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### "Rooming-In" for Infants

Dr. Angus McBryde, of Durham, N.C., stated, in the March 3rd issue of the *Journal of the American Medical Association*, that "rooming-in" of infants (i.e. keeping babies in mothers' rooms) is advantageous to infants, parents, and grandparents, as well as to paediatricians, and hospital administrators. A paediatrician at Duke Hospital and Duke University School of Medicine, Durham, N.C., Dr. McBryde reported on the success of the "rooming-in" plan at the hospital since it was initiated three years ago. During that time 2,067 infants were born at the hospital, with 1,862 of them being kept successfully in their mothers' rooms.

## Un Revue des Rapports

*(Suite de page 37)*

raison des frais de production plus importants, dans un domaine où la concurrence est vive. Nous osons croire que vous accordez au journal toute l'importance qu'il mérit. Vous avez là un organe de diffusion qui est à vous; il ne faut pas en sous-estimer la juste valeur. Il y a deux façons dont les hôpitaux individuels et le personnel hospitalier peuvent lui accorder leur appui: d'abord, en le lisant consciencieusement, et ensuite, en y collaborant chaque fois qu'une idée surgit ou qu'un renseignement vaut d'être diffusé.

J'ajoute que nous sommes très désireux de recevoir des textes à publier en français.

Le docteur Bradley exprima ses remerciements aux Ministres des Gouvernements fédéral et provinciaux, et aux nombreux fonctionnaires de leurs services avec qui le Conseil s'est trouvé en contact; tous en effet lui ont accordé sans compter, leur aide et leur coopération.

Il s'est déclaré honoré d'avoir pu travailler en commun avec les directeurs des associations et conférences provinciales et régionales; avec les directeurs et membres du Comité exécutif du Conseil, dont le jugement nous a été si précieux; et avec le docteur Agnew à qui nous sommes sincèrement reconnaissants des conseils qu'ils nous a prodigués.

Pour finir, le docteur Bradley souligna que ce qui a été réalisé a pu l'être, grâce à l'esprit d'équipe et à l'effort collectif de notre personnel et de tous les autres intéressés.

Je tiens à m'associer au docteur Bradley dans l'expression de ces sentiments.—*M. W. Ross.*

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### Deplores "Spectatoritis"

Stressing that physical and mental well-being are dependent upon individual activity, the Canadian Association for Physical and Health Education and Recreation stated in a release for National Health Week that "in a time when there is also a tendency for play activities to be exploited as commercial entertainment, it is essential that large numbers of our people do not become addicted to *spectatoritis*".

## With the Auxiliaries

*(Concluded from page 62)*

further stated that the success of the new group depended not only on the provincial associations but on every auxiliary. In conclusion, Judge George advised members not to overlook the work of the small auxiliaries as they were just as important as the large ones and were operating against greater difficulties.

Dr. Harvey Agnew, Toronto, expressed his admiration of the splendid work being carried on by the auxiliaries. He stated that a transition in all phases of hospital work is taking place and that now more importance is being placed on voluntary care and assistance than in the past. Even with government grants to aid hospitals, the auxiliaries are still playing an essential part by their contributions and find that they must spend their money wisely.

R. Fraser Armstrong, Kingston, Ont., also addressed the members and stressed that in these times of rising costs a tremendous service can be accomplished by voluntary groups. Mr. Armstrong advised the new group "to think at the top" and to follow the methods of other national associations by having contact with member organizations and by trying to help solve common problems.

A resolution that application be made by the National Council for membership in the Canadian Hospital Council was adopted and presented to the C. H. C. biennial meeting.

Sessions concluded on May 30th with the election of officers and the pledge that the new Canadian National Council of Women's Hospital Auxiliaries would assist in the development and operation of hospitals throughout Canada.

### Officers

*President:* Mrs. O. W. Rhynas, Toronto, Ont.

*Vice-Presidents:* Mrs. H. W. Davis, Kingston, Ont.; Mrs. J. M. George, Morden, Man.; Mrs. James D. Good, London, Ont.; and Mrs. W. P. Fillmore, Winnipeg, Man.

*Secretary-Treasurer:* Mrs. T. J. Lytle, Toronto, Ont.

*Advisory Council Members:* Mrs. Claude R. Wilson, Vancouver, B.C.; Mrs. Forbes Perkins, Vancouver, B.C.; Mrs. W. B. Frost, Melfort, Sask.; Miss Christina Macleod, Winnipeg, Man.; Mrs. John Oliver, Edmonton, Alta.; Mrs. F. Cecil McDougall, Montreal, P.Q.; Mrs. Alton Goldbloom, Montreal, P.Q.; Mrs. James Ross, Truro, N.S.; and Mrs. Ernest Haggerman, Saint John, N.B.

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## Health Care Plans

*(Concluded from page 60)*

payroll, *e.g.*, persons self-employed, retired, student, domestic, farmer, fisherman, and those not working.

Four different types of contracts are being offered to these two new membership classifications. Further information may be obtained from the Maritime Hospital Service Association, 560 Main St., Moncton, N.B.

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*First bug to second bug:* I shouldn't come too near me if I were you, old man. I think I've got a touch of streptomycin.—*The Alchemist.*

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Apply to Box 618K, Canadian Hospital, 57 Bloor St. West, Toronto 5, Ont.

## Coming Conventions

July 15-21—Second Postwar Congress of the International Hospital Federation, Brussels, Belgium.

Sept. 10-14—Fifth World Congress, International Society for the Welfare of Cripples, Stockholm, Sweden.

Sept. 12-15—Canadian Society of Radiological Technicians, Royal Alexandra Hotel, Winnipeg.

Sept. 17-20—American Hospital Association, St. Louis, Mo.

Oct. 10—Catholic Hospital Conference of Saskatchewan, Regina, Sask.

Oct. 11-12—Saskatchewan Hospital Association, Hotel Saskatchewan, Regina.

Oct. 16-19—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver.

Oct. 22-26—A.H.A. Institute on Hospital Purchasing, Moraine Hotel, Highland Park, Illinois.

Oct. 24-26—Associated Hospitals of Manitoba, Winnipeg.

Oct. 29-31—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 1-2—Annual Convention of the Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

Nov. 20-24—Maritime Hospital Association Institute for Hospital Trustees and Administrators, Halifax, N.S.

Nov. 26-30—A.H.A. Institute on Hospital Laundry Management, Kenmore Hotel, Boston, Mass.

### Western Canada Institute

*(Concluded from page 96)*

annual meeting in conjunction with the Institute. The representatives of the British Columbia Hospitals' Association reported that they were authorized to accept responsibility for the Institute in 1952. The co-ordinating committee suggested that the university connection be continued. Dr. A. C. McGugan, Edmonton, was re-elected chairman of the co-ordinating committee.

An innovation was a meeting of hospital association secretaries to discuss problems of inter-association liaison. The need for an even closer relationship was evident, and all agreed that the Canadian Hospital Council, as the co-ordinating body for the hospital organizations, must feel free to take firmer steps in developing an information service and in co-ordinating interest and activities among regional associations and conferences.

Congratulations must be extended to Edgar Dutton, president of the Associated Hospitals of Alberta, to officers and directors of the host association, to Dr. A. C. McGugan, general chairman of the Institute, to L. R. Adshead, general secretary, and to members of the various committees in charge of arrangements, for the quality of the program and the excellence of all facilities and arrangements which made this Institute so highly successful.—*Murray W. Ross.*

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